Issue Brief

White House Conference on Aging 2005

No.1 | February 2005

Introduction

This report is the first in a series from the Alliance for Retired Americans Educational Fund, leading up to the White House Conference on Aging (WHCoA), tentatively scheduled for October 23-26, 2005 (this may change to a later date) in Washington, D.C. As a framework for the series, this brief presents background on the conference, a profile of the baby boom population, which will be a major focus of the October meeting, a history of WHCoAs, and the reflections of a federal official who participated in the first conference in 1961. Subsequent briefs will focus on issues and programs that must be considered at the WHCoA as the nation's boomers become retirees. These topics will include Social Security, Medicare, pensions, work and retirement, health care status and coverage, long-term care, housing, transportation and the Older Americans Act.

White House Conference on Aging Delegate Selection

Congress and governors will select more than half of the 1,200 delegates to the White House Conference on Aging. Each member of Congress will have one slot; governors will appoint 200 delegates altogether. Each state will have a minimum of two delegates; states with a larger percentage of older persons will have more. **Individuals who wish to attend should contact their Representative, Senators or governor and request to be named as their designee. The deadline is March 15.** The remainder of the delegates will represent national aging, veterans' and other allied organizations, universities, business and industry and will be selected by the policy committee. Conference delegates will include professionals, minorities, individuals from low-income families and rural areas, and representatives of federal, state and local governments. A majority of delegates must be age 55 or older**.**

Alliance members should also attend WHCoA events held throughout the country to participate in the development of resolutions to be voted on at the national conference. Updates on the delegate selection process and events will be posted on the conference website at: **www.whcoa.gov**. Also, watch for updates on the Alliance website at: **www.retiredamericans.org**.

The 2005 White House Conference on Aging

In 2000, Congress amended the Older Americans Act to authorize the President to convene a WHCoA no later than December 31, 2005. President George W. Bush has scheduled the first WHCoA of the 21st century for October 23-26, 2005 in Washington, D.C. The conference theme is "The Booming Dynamics of Aging: From Awareness to Action."

The President and Congress appointed a 17-member policy committee responsible for planning and implementing the conference including an agenda, delegate selection and a post-conference report. Dorcas R. Hardy, Social Security Administration commissioner under President Ronald Reagan, chairs the committee. The policy committee's meetings are open to the public and scheduled for the following dates in 2005: February 10, May 17-18, July 19-20, and September 20-21. An advisory committee will also be named.

The policy committee held "listening sessions" from August 2004 through January 2005. Richard Fiesta, director of government and political affairs for the Alliance for Retired Americans, testified at one of the first sessions in September 2004 and made policy recommendations that will affect older Americans in the coming decade. Fiesta spoke about the importance of protecting Social Security from privatization, strengthening Medicare and providing more affordable housing for seniors. Subsequent "solutions forums" and mini-conferences in 2005 will focus on recommendations for resolutions. These are also official WHCoA events.

Much of the conference agenda will address federal and state policies and programs serving baby boomers as they become eligible for Social Security and Medicare benefits. The policy committee will select approximately 100 resolutions prior to the conference. Delegates will be responsible for reducing resolutions to the mandated 50 and recommending implementation strategies.

Purpose of the 2005 WHCoA

"The purpose of the Conference…shall be to gather individuals representing the spectrum of thought and experience in the field of aging to:

1. Evaluate the manner in which the objectives of this [Older Americans] Act can be met by using the resources and talents of older individuals, of families and communities of such individuals, and of individuals from the public and private sectors;
2. Evaluate the manner in which national policies that are related to economic security and health care are prepared so that such policies serve individuals born from 1946 to 1964 and later, as the individuals become older individuals, including an examination of the Social Security, Medicare, and Medicaid programs…. in relation to providing services under this Act, and determine how well such policies respond to the needs of older individuals; and
3. Develop not more than 50 recommendations to guide the President, Congress and Federal agencies in serving older individuals."

—Older Americans Act Amendments of 2000 (P.L. 106-501)

Who Are the Baby Boomers?

The estimated 77 million baby boomers were born between 1946 and 1964. In 2005, they are between ages 41-59.

Other facts distinguish the baby boomers. Divorce rates for baby boom women is double that for the previous generation (19.1 percent vs. 9.5 percent). Nearly 8 percent of baby boom women never married.[1] The fertility rate of 3.5 children for the women who produced the baby boomers has declined to 2 children. Ten percent of baby boomers are foreign born, and 14 percent speak a language other than English at home.[2] The proportion of minorities in the 65+ population will increase dramatically over the next three decades because of baby boomer demographics: there will be a 95.5 percent increase of older whites and a 154.6 percent increase among older blacks; a 417.1 percent increase for older Hispanics and a 380.1 percent increase for those of other races (Asian/Pacific Islander, American Indians, Eskimos, Aleuts) by 2030.[3]

An 18-year span in a population sub-group logically indicates that baby boomers are not socially and politically homogeneous. The advance wave of boomers came of age in the 1960s, a period of social protests against the Vietnam war, for civil rights, and women's rights. The youngest boomers, on the other hand, came of age in the 1980s, a period of social and economic conservatism under the Reagan administration. Thus, Presidents John F. Kennedy and Ronald Reagan, whose administrations were markedly different, are the national leaders boomers most admire for making contributions to the United States. Majorities of boomers consider the civil rights movement (59 percent), the women's rights movement (51 percent), the Vietnam War (67 percent), and the 9/11 attack (90 percent) to be major influences on their views of government and politics.[4]

Demographic Snapshot of Baby Boomers

Gender

51 percent are women
49 percent are men

Race/Ethnicity

80 percent are white, 12 percent are black, 3 percent Asian/ Pacific Islander, 9 percent Hispanic origin of any race

Marital Status

69 percent are married and 71 percent live in dual-income households

Median Household Income

$62,300

Family Relationships

63 percent have lost at least one parent
35 percent are responsible for the care of a parent

Home Ownership

78 percent own a home

Education

85 percent have a high school degree or higher; 30 percent have a college degree or higher

Work Status

68 percent work full-time
12% work part-time

Sources: Census Bureau. Population, Social and Housing Characteristics of Baby Boomers 26 to 44 years old: 1990; AARP. Baby Boomers Envision Their Retirement II. 2004.

Significant Events in Lives of Baby Boomers

1940s	1950s	1960s	1970s	1980s	1990s	2000s
GI Bill: allows many parents of baby boomers to attend college, buy homes	Korean War	Bay of Pigs	Kent State shootings	Reagan years	USSR dissolves; Cold War ends	2000 election dispute
Suburbs, shopping centers grow	Onset of TV age	Berlin Wall	Vietnam War ends	Challenger disaster	Health care reform fails	9/11 terrorists attacks
Cold War begins	Transistors	Vietnam War	Roe v. Wade	AIDs	Tech/ Telecom boon: internet, dotcoms, cell phones, digital cameras	Wars on Terrorism, Iraq
	Sputnik	Movements: Civil Rights, Women's Rights, Anti-War	Watergate, Nixon resigns	"Evil Empire" glasnost; perestroika		G.W.Bush re-election
	"Duck-n-Cover" fallout shelters	Beatles Counter-culture Woodstock	Oil crises	Berlin Wall falls		
	Rock-n-Roll	Kennedys, King Assassinations	Hostages in Iran			
	School integration	Moon landing	Three Mile Island			

Baby Boomers in Retirement

Overall, nearly seven in 10 (68 percent) boomers are optimistic about their retirement years, but 30 percent are not. While we do not know how well baby boomers will adapt to growing older either in retirement or as workers, we do know that most will be between ages 66 and 67 before they are eligible for full Social Security benefits.[5] Sixty-three percent feel fairly sure they can count on Social Security for income during retirement, and 45 percent say lack of Social Security would have a major impact on their retirement; 59 percent expect to depend heavily on personal investments.[6]

As they near retirement, boomers will likely want to work in a changed work structure—four days a week, or on a project basis, or with one-year sabbaticals. Currently one-half of older workers partially retire before full retirement or they "unretire" and go back to work. The unretirement rate in the first five years after first retirement is 24 percent, higher among those retiring at younger ages—36 percent among those retiring at ages 51-52. The average unretirement spell lasts about four years.[7]

Seventy-nine percent of boomers say they plan to go back to work during their retirement years. Of those, 15 percent will start a business and 7 percent will work full-time at a new job,

30 percent will work part-time for enjoyment and 25 percent plan to work part-time for needed income.[8] However, many who plan to work will not. Despite the Age Discrimination in Employment Act of 1967, which prohibits workplace discrimination against persons age 40 and older, the "silver ceiling" still exists and age discrimination often prevents continued employment or advancement. In addition, pension regulations can complicate continued participation in the workforce.

It is generally assumed that retired boomers will be healthier than today's retirees. However, the U.S. lags far behind other developed countries for average life expectancy at birth and highest number of years lived in good health. That trend is likely to continue.[9] Twenty-seven percent of boomers have already survived a major illness and 22 percent expect to have serious health problems.[10] Additionally, one in four baby boomers are obese, significantly higher than boomer obesity rates in 1991, which ranged between 11-16 percent.[11] The economic and health status prospects of baby boomers in later years will be examined in more detail in future issues.

Forty-five percent of baby boomers say lack of Social Security would have a major impact on their retirement.

History of White House Conferences on Aging

Three national conferences preceded the first **White House Conference on Aging in 1961**. In 1950, President Harry S. Truman recognized the need to convene a conference focused solely on addressing the challenges of a rapidly growing older population. The 816 delegates to that conference made recommendations for national action. Two subsequent conferences in 1952 and 1956 included delegates from most states and territories. These and all subsequent conferences took place in Washington, D.C.

The White House Conference on Aging Act (P.L. 85-908) of 1958 authorized the 1961 White House Conference on Aging calling for a nationwide citizens' forum to focus public attention on older Americans. Congress intended that such a conference be held every 10 years. In 1959, a National Advisory Committee, led by Dr. Arthur Flemming, Secretary of Health, Education and Welfare, began meeting. Two years of pre-conference study and analysis at the state and local levels produced recommendations considered at the conference.

President Dwight D. Eisenhower opened the conference, held January 9-12, 1961, but it was the John F. Kennedy and Lyndon B. Johnson administrations that implemented the recommendations. More than 3,000 attended, including 2,800 voting delegates. Fifty-three states and territories as well as 300 national organizations were represented.

Many recommendations from the conference became law within a few years. These included enactment of Medicare and Medicaid in 1965 as Titles XVIII and XIX, respectively, of the Social Security Act. The

Older Americans Act, also enacted in 1965, established the Administration on Aging and state units on aging. Other major legislation included Social Security amendments providing additional support to beneficiaries, and amendments to the 1961 Housing Act and the Community Health Facilities Act requiring special provisions for the aged. New programs were created to provide older adults with job training and volunteer opportunities.

The **1971 White House Conference on Aging** took place November 28-December 2, 1971, during President Richard M. Nixon's administration. Over 4,000 delegates attended. The primary objectives were to establish an income assistance program to reduce poverty among seniors and improving transportation services for rural and urban older Americans. Approximately 75 percent of the nearly 200 recommendations were partially or fully implemented. The Supplemental Security Income program was established in 1972 as a federal-state program to provide a basic safety net for older Americans, and the blind and disabled of all ages to meet their most basic needs. During the 1970s, the Urban Mass Transit Act was amended to provide reduced fares on mass transit and transportation in rural areas for seniors and persons with disabilities. Resolutions also launched greater coordination of services among federal, state and local area agencies on aging and created a national nutrition program for seniors. The conference's recommendations also created the House Select Committee on Aging and the Federal Council on the Aging.

The **1981 White House Conference on Aging** took place November 19-December 3, 1981. It was planned and implemented under the Carter and Reagan administrations; 2,000 delegates and 1,150 observers attended. In an effort to emphasize grassroots involvement, over 9,500 community forums, single issue mini-conferences, and state conferences were held during the two years preceding the conference. New issues for consideration surfaced from the forums including elder abuse, negative stereotypes and ageism, intergenerational programs, long-term care and adult education. Approximately 700 official recommendations for legislative and administrative action were proposed but little action was taken. President Reagan's massive cuts in domestic spending for social programs prior to the conference and his proposal to cut Social Security benefits overshadowed the WHCoA's recommendations.

The **1995 White House Conference on Aging** took place May 2-5, 1995. Over 800 pre-conference events were held throughout the country. More than 3,000 including 2,217 delegates from all the states and territories attended. Governors, members of Congress and constituent organizations including national aging organizations selected 80 percent of the delegates. In contrast to earlier conferences, the 1995 conference proposed few new initiatives. Delegates, assisted by expert advisers, concentrated instead on resolutions reaffirming support for existing programs and recommendations for strengthening each of them.

Dorothy McCamman: One Woman's Account of the Origins of Medicare and the 1961 WHCoA

In 1961, Dorothy McCamman was assistant director of research at the Social Security Administration and served as technical director for three WHCoA sections: Income Maintenance, Social Services, and the Impact of Inflation on Retired Persons. Following are excerpts, with explanatory insets in brackets, from her account recorded December 1979, of how the policy recommendation for the program that became Medicare evolved in preparation for and during the 1961 White House Conference on Aging. The conference brought together supporters of the Medicare or "health care under Social Security" approach. However, they had to contend with the strong opposition from the American Medical Association (AMA) and insurance companies. It was in the Income Maintenance section, chaired by former SSA Commissioner Charles Schottland, where the financing for Medicare was deliberated.

"By way of introduction let me talk about the development of the proposal for hospital insurance for Social Security beneficiaries, which evolved into Medicare. In the early 1950s, I was called into the office of my boss, Dr. I.S. Falk, Director of Research for Social Security. He had just returned from a meeting with Oscar Ewing, Federal Security Administrator, where they had agreed to abandon the push for national health insurance and to develop a proposal for hospital insurance for the aged and other beneficiaries of Social Security. They had recognized that such a proposal would be called the camel's nose under the tent but they had said, 'No, this instead was a group that couldn't be handled by private insurance and therefore the government must intervene.' My job was to write a background paper… setting forth the need for the proposal: that the aged have incomes half that of the younger, that their hospital costs are two to two and one-half times that of younger persons, that there was a complete lack of private insurance to cover their risks. These are the essential facts that were debated over the years and there were perhaps tens of thousands of printed pages before the Medicare proposal was finally legislated."

[Prior to the conference, states received grants for fact-finding and preliminary state conferences.] "Meanwhile, the states had been preparing their fact-finding papers and had been holding their state conferences. Many of these state conferences were dominated by insurance executives and doctors….Not surprisingly then, the recommendations coming from the state conferences were much more regressive than would be called for by the fact-finding reports which had been prepared under the direction of technicians."

"Two major conference addresses…undoubtedly had an impact on the thinking of the delegates. The first was by Marion B. Folsom, formerly Secretary of Health, Education and Welfare and Under Secretary of the Treasury who called Social Security financing of medical care the logical plan, and stated that there is no basis for describing it as socialized medicine. Under the Social Security program he told the delegates with conviction, 'The individual would still have the same free choice as to hospitals and doctors that he now has.' The other speaker who advocated the Social Security approach was Arthur Larson, former Under Secretary of Labor.…he defined the proper role of government as doing for people what needs to be done but what they cannot do at all or do so well. Social Security, he said, is not accomplishing its purpose of protecting individuals from becoming social problems if hospital and medical charges consume wage-loss benefits."

[Sections were subdivided into workgroups for intensive discussion of various topics.] "…six of the seven workgroups [within the Income Maintenance Section] reported majorities favoring the use of the Social Security approach."

[Adopted recommendations were those approved in the sections, they were not voted on in the plenary sessions.] " Prior to voting, the delegates heard presentations of the minority and majority positions as determined by the recommendations coming out of the workgroups….The teller vote that followed resulted in the section's endorsement by a vote of 170 to 99 for the use of the Social Security mechanism as the basic means of financing health care of the aged…. Historians of Medicare have called this vote the first defeat suffered by the AMA in its long fight against a government role in the financing of health care." [The AMA's attempt to have a counter vote in the Health Section was ruled out of order by the conference chair former Republican Congressman Robert Kean of New Jersey and the Medicare recommendation stood.]

Endnotes

[1] Alicia H. Munnell. Why Are So Many Older Women Poor? Boston College Center for Retirement Research. April 2004.
[2] Census Bureau. Population, Social and Housing Characteristics of Baby Boomers 26 to 44 years old: 1990.
[3] U. S. Administration on Aging. Statistics. Acting Into the 21st Century: Demography.
[4] AARP. Political Behavior and Values Across the Generations. A Summary of Selected Findings. July 2004.
[5] In 2003, the retirement age for receiving full Social Security benefits began gradually rising from 65 to 67 as a result of Social Security Amendments in 1983.
[6] AARP. Baby Boomers Envision Their Retirement II-Key Findings. May 2004.
[7] Nicole Maestas. Back to Work: Expectations and Realizations of Work After Retirement. University of Michigan Retirement Research Center. July 2004.
[8] AARP. Baby Boomers Envision Their Retirement II-Key Findings. op cit.
[9] World Health Organization. World Health Report 2003.
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[11] Center for Disease Control and Prevention. Obesity Trends: 1991-2001 Prevalence of Obestity Among U.S. Adults, by Characteristics.

This report was researched and written by Dianna M. Porter, director for policy. It is a publication of the Alliance for Retired Americans Educational Fund (ARAEF), the research and educational branch of the Alliance for Retired Americans. The ARAEF is a 501(c) (3) organization that focuses primarily on retiree issues.

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Issue Brief

Alliance for Retired Americans EDUCATIONAL FUND

Social Security for All Ages

No.2 | April 2005

Summary

For nearly 70 years, Social Security has been the bedrock of income security for nearly all Americans, providing benefits to retirees, those with disabilities, and the survivors of retired and deceased workers. The program has never missed a benefits payment in its history. However, the program is threatened by proposals to divert a portion of payroll contributions from the Social Security Trust Fund into private accounts and cut benefits.

This brief draws upon a report released earlier by the Alliance for Retired Americans Educational Fund, *Social Security Under Attack,* to highlight how the program works, the protections that it provides, key points about the effects of privatization and how minor adjustments will provide for promised benefits over the next 75 years.

The Benefit Cuts and Privatization Proposals

President Bush is making privatization of Social Security his top domestic priority. His proposal would divert some of the funds that normally go into the Social Security Trust Fund into private investment accounts. According to an internal White House memo, the President also plans to cut benefits by

Social Security At-A-Glance

In 2005, almost 48 million people, or 1 out of every 6 Americans, will receive Social Security benefits.

Retired Workers	30 million	$955 average monthly benefit
Dependents	3.1 million	
Disabled Workers	6.2 million	$894 average monthly benefit
Dependents	1.8 million	
Survivors	6.7 million	$920 average monthly benefit

Source: Social Security Administration

President Bush's Commission to Strengthen Social Security

In May 2001, President Bush appointed 16 people to his Commission to Strengthen Social Security, all of whom publicly supported private individual accounts. In December 2001, the commission released its final report, which outlined three options for reform. All three options included diversion of payroll taxes from the Social Security Trust Fund into private accounts—between one to four percentage points. None of the three options addressed Social Security's long-term solvency.

Option 2 of the Social Security Commission's report is frequently cited as the likely model for the President's plan.

The basics of Option 2 are:

- Four percent of taxable payroll contributions made to Social Security would be diverted to private accounts;
- Initial benefit calculation would be indexed to prices instead of wages;
- Cuts in guaranteed benefits, which would apply to all workers whether or not they have private accounts;
- Additional benefit cuts for workers with private accounts;
- Workers could not access account until retirement age; and
- General revenue transfers would be required from 2021-2054 in order to pay benefits.

changing the base for initial benefits from a wage-indexed system to a consumer price-indexed payment.[1] Although privatization proposals have circulated for over 20 years, the anticipated model in the current debate comes from Option 2 of the President's 2001 Social Security Commission report. (See box.)

Benefit Cuts

Initial Social Security benefits are calculated to reflect the standard of living a person enjoys based on earnings. When benefits are calculated at age 65, or normal retirement age, based on earnings over a lifetime, the salary earned in prior years is adjusted upward to reflect wage growth. As a result, each succeeding generation of workers enjoys higher Social Security benefits that reflect the higher average wages that generation has earned.

The price-indexing proposal would replace the wage-based formula with one based on the rise in consumer prices, essentially the inflation rate. Wages generally rise faster than price inflation, thus a price-indexing formula would result in lower salary adjustments and benefits at retirement.

Over time, the benefit would be lower for each generation of new retirees. For someone retiring in 2032, traditional benefits that are price-indexed would be cut by 18 percent. For someone retiring in 2066, the benefit would be reduced by 41 percent.[2] (See Table 1.)

The benefit cuts would apply to all beneficiaries whether or not they had a private account. Workers who choose private accounts will likely have additional benefit cuts.

An alternative proposal would continue wage indexing of benefits for low earners, impose price indexing of benefits for high earners and use a mix of wage indexing and price indexing for average wage earners. However, this so-called "progressive indexing" would impose substantial benefit reductions on average wage workers and make the system unattractive to high earners. For an average wage earner who retires in 2075, the benefit reduction would be 28 percent or $7,629 in today's dollars.[3]

Table 1. Benefit Cuts Under President Bush's Plan

Year turning age 65	Traditional Benefits (for those who do not opt for private accounts)
2012	-0.9
2032	-18.2
2052	-32.5
2066	-41.0

Private Accounts

Currently, workers contribute 6.2 percent of their taxable earnings to the Social Security Trust Funds, employers contribute an equal amount. Thus, 12.4 percent of taxable earnings up to $90,000 go to the Social Security Trust Funds. President Bush proposes to allow workers younger than age 55 to divert 4 percent, or one-third of Social Security contributions, into a private investment account. The limit would be $1,000 a year initially, rising $100 per year afterwards.

Private accounts will be very costly for both the Social Security program and those choosing the accounts because of offsets. Under the Bush plan, workers age 44 to 59 would be eligible for the program in 2009, with those age 32 to 60 added in 2010, and younger workers added in 2011. With this scenario, the transition costs increasing the government's total debt would be $1.4 trillion over the first 10 years of the plan and $4.9 trillion over the first 20 years.[4]

A worker choosing a private account option would owe a "debt" to the Social Security Trust Fund to offset the funds that had been diverted to the private accounts plus interest. However, the funds paid back to the Trust Fund would be less than the amount that the Trust Fund would lose, thus aggravating the financing gap of Social Security.[5]

When workers retire, the Bush plan would subtract from their traditional Social Security benefit all of the money deposited in their private accounts, plus 3 percent interest above inflation. The offset, or "clawback," equals the amount the White House assumes those deposits would have earned in Treasury bonds if they had gone into Social Security. In effect, the accounts work as a loan from the government to be paid back upon retirement at an inflation-adjusted 3 percent interest rate.

In addition, the accounts will be subject to the volatility of the stock market and high administrative costs. An examination of foreign examples reveals that the World Bank acknowledges that in Chile one-half of the pension contributions of the average worker who retired in 2000 went to management fees. In Great Britain, such costs eat up 20 to 30 percent of contributions.[6] In contrast, the Social Security Administration spends just 1 percent of income for administrative costs.

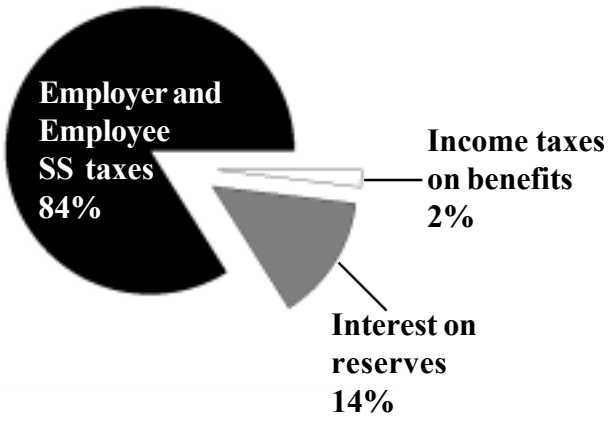
Who Wins With Private Accounts?

The investment industry would acquire millions of accounts for which they could charge substantial fees for administering them. One calculation of the financial community's gain in fees is $940 billion, amounting to one-quarter of the currently anticipated revenue of the entire financial sector for the next 75 years. Wall Street's own association, the Securities Industry Association, acknowledges windfalls of $39 billion to $279 billion or more over the next 75 years.[7] Insurance companies would gain from the sale of annuities as those who have private accounts would be required to purchase annuities at retirement. In today's insurance market,

Understanding the Trust Funds

Each year, the government reports the amount of money in the Old Age, Survivors, and Disability Insurance Trust Funds, the amount added or redeemed in a given year, as well as the interest earned. Over the last 20 years, the Social Security Administration has been putting aside ever larger surpluses to provide for the pending baby boomers' retirements. As a result of interest earnings, the Social Security actuaries project fund assets will reach $4.7 trillion in 2017, increasing by another $1.3 trillion for the nine years after that.[8] Between then and 2041, Social Security will have to supplement its income by drawing down on its reserves; but these are projected to be sufficient to pay full benefits until 2041. After 2041, the system will be able to pay 74 percent of the promised benefits. The Congressional Budget Office uses more optimistic assumptions and projects that the trust funds can pay full benefits until 2052 and 78 percent of benefits after that.[9]

Figure 1. Income Received by Social Security Trust Funds
Estimates for 2005



Source: National Academy of Social Insurance, 2005

In 2005, the Social Security Trust Funds will receive income of $690 billion and pay out $527 billion, leaving a surplus of $163 billion. Employer and employee taxes account for 84 percent of the income; interest on the reserves, 14 percent; and income taxes on benefits, 2 percent**.** (See Figure 1.) Almost all the payments will be for benefits with less than one percent spent on administration. The surplus is invested in interest-bearing U.S. government securities. By the end of 2005, the trust funds reserves are estimated to be $1.8 billion.[10]

The Treasury bonds held by the Trust Funds are every bit as real as the bonds held by banks, corporations, or individuals. Throughout the history of the United States, the federal government always paid off its bonds which are backed by the full faith and credit of the federal government.

annuities account for only 5 percent of the industry's revenues. Current stockholders, mainly wealthy individuals, would benefit from the President's plan because privatization would raise the price of existing stock.

The Inheritance Myth

President Bush asserts that his plan would allow investors to pass on their accounts to their heirs when they die. What he does not say is that the Social Security survivorship benefit paid to the minor children and spouses of the deceased worker would be substantially cut by his formula change in evaluating earnings. If a worker dies at a young age, no amount of inheritance would offset the loss of benefits resulting from the deep cuts in benefits and the potential offsets for diverting funds to a private account.

Moreover, the President indicates that when they retire most individuals would have to transfer their invested funds into an annuity. Thus, there would be no account funds for an inheritance, except for the provisions of the annuity. Under present law, a retiree's spouse at full retirement age receives 100 percent of the worker's Social Security benefit; but under the President's plan, the benefit would be reduced by both the benefit cut and by the funds diverted to a private account. These cuts would dwarf any inheritance incorporated into an annuity.

Social Security today guarantees that everyone who works, and their families, can live decently in retirement or in disability.... [It] is a bridge that spans class, race, income and generations.

A Contrived Crisis

President Bush speaks about an $11 trillion shortfall that threatens Social Security creating an immediate crisis. However, this dire prediction is based upon a projection first made by the trustees in the spring of 2003 that extends the normal 75-year projection period into infinity. Using the more normal actuarial projection of 75 years, the gap shrinks to $4 trillion in net present value (1.92 percent of taxable payroll) or to $2 trillion (1.0 percent of taxable payroll) according to the Congressional Budget Office.[11]

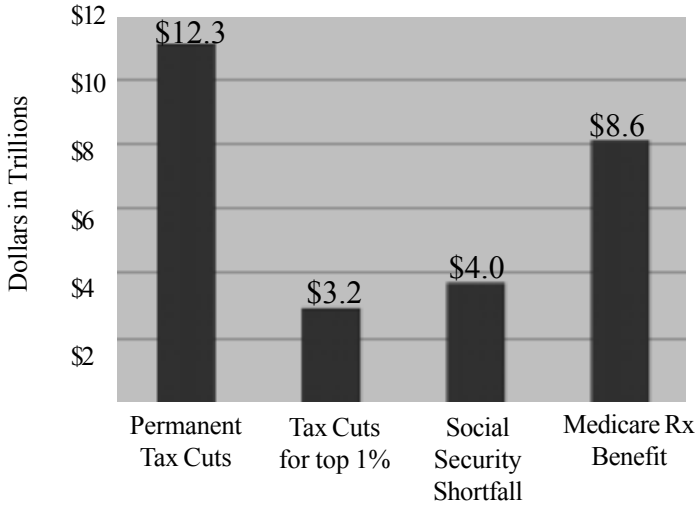
The American Academy of Actuaries objected to the change in estimation horizons and wrote to the trustees that infinite projections provide "little if any useful information about the program's long-range finances" and are "likely to mislead anyone lacking technical expertise... into believing that the program is in far worse financial condition than is actually indicated."[12]

The $4 trillion shortfall in Social Security pales in comparison to the costs to the Treasury of the tax cuts enacted since 2001. Over the next 75 years, the President's tax cuts, if made permanent, will cost $12.3 trillion, triple Social Security's gap. The shortfall in the Medicare program due to escalating health care costs and the new prescription

drug benefit is twice the size of the Social Security shortfall. Tax cuts for the top 1 percent alone will cost $3.2 trillion, if made permanent.[13] (See Figure 2.)

Figure 2. Tax Cuts and Medicare Rx Benefit Cost More than Social Security Shortfall

In Trillions of Dollars over 75 Years



Source: Center for Budget and Policy Priorities, March 2005

Better Solutions

There is no crisis with the Social Security system as the currently projected shortfall occurs after 2041 or 2052. Moreover, these projected shortfalls can be met in a variety of ways. Some favor an increase in taxes such as a rise to 7.1 percent on employer and worker contributions to Social Security to meet any projected short-fall for 75 years. Others favor a cut in benefits. Some suggest raising the retirement age further – perhaps to age 70. Others recommend that there should be increased incentives for workers to delay retirement, thus reducing the long-term costs of the system. Still others suggest that the Social Security surplus be invested in stocks, rather than in government bonds.

However, the Alliance for Retired Americans has repeatedly called for a change that would raise or remove the current $90,000 cap on taxable earnings. This would increase the contributions of the 6 percent of earners who are paid more than the capped amount. AFL-CIO President John Sweeney has also suggested that, rather than repealing the inheritance tax after 2009 as President Bush proposes, the inheritance tax on estates, above $3.5 million for an individual or $7 million for a couple, be directed into the Social Security Trust Funds. Maintaining the tax would affect one-half of one percent of all estates.

Raising the cap and dedicating the estate tax to Social Security would meet over two-thirds of the projected shortfall, and would improve the progressivism of the payroll tax. Meeting most of the projected shortfall would allow full promised benefits to be paid over the forecasting period of 75 years to retirees, disabled beneficiaries, and survivors.

Conclusion

The Social Security debate raises fundamental questions about what kind of society American strives for in the future. Social Security today guarantees that everyone who works, and their families, can live decently in retirement or in disability. Furthermore, survivors of deceased workers are protected.

The President proposes abandoning this guarantee and substituting it with private accounts, which would be subject to the vagaries of the stock market. This effort, if successful, would shift the risks of the economy from the nation as a whole to the individual and jeopardize the one guaranteed source of income for all Americans.

Social Security is a bridge that spans class, race, income and generations. The program is under the most serious assault in its 70-year history. If Social Security is to survive as the program that provides guaranteed, risk-free, inflation-adjusted lifetime protection, then the fight for the program's survival must be joined by everyone—workers, retirees, those with disabilities, families and survivors, and especially young people—because everyone has a stake in the outcome.

Endnotes

[1] Internal White House memo, "Some Thoughts on Social Security" from Peter Wehner, Director of White House Strategic Initiatives. January 3, 2005.
[2] Report of the President's Commission to Strengthen Social Security. December 2001; Center on Budget and Policy Priorities and the Century Foundation. "Reducing Benefits and Subsidizing Individual Accounts: An Analysis of the Plans Proposed by the President's Commission to Strengthen Social Security." 2002.
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Social Security Is a Valuable Investment

Social Security is worth a ...

Retirement policy of $250,000

Disability policy of $353,000

Life insurance policy of $403,000

Source: National Academy of Social Insurance

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Issue Brief

Medicare Prescription Drug Benefit: A Guide Through the Maze

No.3 | May 2005

Introduction

The prescription drug benefit provided under the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 takes effect on January 1, 2006. ***In the intervening months, Medicare beneficiaries must make a number of decisions and take action. Prescription drug coverage will not be automatic.*** Unlike Medicare Part B where beneficiaries must "opt out" of an automatic enrollment for those who receive Social Security, most beneficiaries will have to "opt in" or actively enroll in a drug plan in order to receive the drug benefit. This report is intended to provide basic information individuals will need during the coming months to understand the benefit, the implementation process, the decisions and actions they must take, and the resources available to them. A subsequent brief will examine the assistance that will be available for low-income beneficiaries.

Drug Benefit Basics

The MMA drug benefit will be Part D under Medicare. Those who are eligible to receive the benefit are persons who are either entitled to or enrolled in Medicare Part A (Hospital Insurance) or Part B (Medical Insurance for doctor services and outpatient care).

Most individuals will obtain drug coverage through private plans, either a stand-alone prescription drug plan (PDP) offered by an insurance company or

Medicare Drug Benefit Out-of-Pocket Costs

- Under the standard benefit beneficiaries in 2006 will pay[1]:
- A monthly premium estimated at $37 ($444/year);
- A deductible of $250;
- 25 percent of drug costs between $251 and $2,250;
- 100 percent of drug costs between $2,251 and $5,100 (the $2,850 coverage "gap" or "doughnut hole"); and
- The greater of $2 for generics, $5 for brand drugs, or 5 percent co-insurance after reaching the $3,600 out-of-pocket limit or $5,100 catastrophic threshold.

through a Medicare Advantage plan with prescription drug coverage (MA-PD) offered by a health maintenance organization (HMO), preferred provider organization (PPO), or Private Fee-For Service (PFFS) plan (See Glossary, p.6). Beneficiaries with employer/union-provided drug coverage and those already enrolled in Medigap plans (Plans H, I, and J) could have their coverage continue, but there might also be changes for them.

Since the new drug benefit will be offered by private plans, the formulary or covered drugs, premiums, co-payments, and pharmacy network may vary substantially. Some plans may be more generous than the basic benefit for a higher monthly premium. Plans must cover at least two drugs in each therapeutic category and class, but they do not have to cover every drug. ***Beneficiaries will have to decide which available plan best addresses their medication needs. If beneficiaries can't find a plan that includes every one of their drugs, they will have to pay all the costs for the uncovered drugs.*** The costs for these drugs will not count towards the plan's deductible nor towards reaching the end of the gap in coverage. Beneficiaries will also have to pay all the costs of their drugs when they fall into the coverage gap.

Since the new drug benefit will be offered by private plans, the formulary or covered drugs, premiums, co-payments, and pharmacy network may vary substantially.

Prescription Drug Benefit Timeline

Since enactment of MMA on December 8, 2003, transitional assistance in the form of drug discount cards with low-income subsidies was provided during 2004 and continues through 2005. The discount cards will phase out on January 1, 2006. Individuals can continue using their discount card until they enroll in a drug plan or until May 15, 2006, when drug plan enrollment ends.

The Centers for Medicare & Medicaid Services (CMS), the agency responsible for implementation, has undertaken a massive effort to launch the benefit on time. In December 2004, CMS announced the establishment of 34 prescription drug plan regions and 26 Medicare Advantage regions and published the final rules for the benefit in January, 2005.[2] Since then, health plans wishing to offer either a PDP or a MA-PD plan in the regions have completed the application process and submitted formularies for review to CMS. The employer/union application and formulary process for either a subsidy or waiver to offer a Part D plan follows a slightly later schedule than the other plans.

The calendar on the next page shows the approximate timeline for continuing implementation of the benefit from May 2005 through the enrollment deadline of May 2006. At the time of publication, there are a number of unknowns, such as plan sponsors and details, that won't be revealed to beneficiaries until the fall of 2005.

Key Dates for MMA Implementation

2005

May 2005	June	July	August
• Social Security Administration (SSA) begins mail notices to 20 million beneficiaries informing of possible eligibility for low-income subsidy (LIS). Mailing continues through mid-August. • CMS notifies beneficiaries "deemed eligible" they do not have to apply for subsidy; continues through June. • Plan sponsor applications approved/disapproved.	• Low-income beneficiaries can begin to apply for assistance with drug costs at SSA, state Medicaid agencies, SHIPs, area agencies on aging. • Bids from health plans due at CMS by 6th.	• SSA and state Medicaid agencies begin eligibility assessments for low-income subsidy on 1st. SSA makes scannable application available on-line. • Employer/unions Part D bids due on the 1st. • Favorable determination of plan bids must be made by CMS by 15th.	• Employer/union drug subsidy application available.
September	**October**	**November**	**December**
• CMS enters contracts with approved plans. Fallback plans activated if needed. • Employer/union retiree subsidy application due by 30th. • Rx discount card sponsors notify enrollees of status of cards and what happens with benefit. • Medigap plans send credible coverage notice to enrollees. Continues to November 15.	• Auto assignment for dual eligibles in PDPs begins if they do not select a plan. • Marketing by PDPs and MA-PDs may begin on 1st. • On 15th, "Medicare and You" 2006 handbook mailed to all beneficiaries. CMS also sends all beneficiaries info describing available Part D plans. • Employers/unions applications accepted/rejected. • MA plans send annual notice of changes to enrollees.	• Enrollment in drug plans begin on 15th; continues to May 15, 2006. • Employers/unions must notify retirees of coverage status and options by 15th. • Beneficiaries may still apply for low-income subsidy after enrolling in a plan-starts from date application is filed.	• Dual eligibles may purchase 3 months of Rx prior to losing Medicaid Rx coverage.

2006

January 2006	February	March - April	May
• **Rx benefit begins for those enrolled on 1st** • Medicare Rx discounts cards phased out. • Dual eligibles lose Medicaid coverage for Rx drugs; will be auto enrolled if not in a plan.	• Enrollment continues. • Subsidy payments to employer/union plans begin.	• Enrollment continues.	• Enrollment period without penalty ends on 15th. • Late enrollment fee of 1% per month begins. Next open enrollment period November 15-December 31, 2006.

MMA and Other Drug Coverage

Medicare beneficiaries who have supplemental prescription drug coverage from other sources should determine their coverage status as it could change.

Employer/union.[3] CMS estimates 11.4 million or 33 percent of the Medicare 65+ population have employer or union coverage and that 9.8 million or 86 percent will continue receiving their employment-based drug coverage. [4]

There are basically two options available for employers and unions with drug coverage plans: apply for the retiree drug subsidy for continuing drug coverage for their retirees, or sponsor a prescription drug plan under Medicare Part D. To qualify for the retiree subsidy, they must meet a "two-pronged" test to show their benefit is at least as generous as the standard Part D benefit. [5] For employers/unions contributing a certain amount to retiree drug costs, CMS estimates an average tax-free drug subsidy payment of $668 per participant in 2006.[6] ***Retirees should contact their benefits administrator to ascertain what their employer/union intends to do.*** If CMS determines that an employer/union plan is eligible for the subsidy, retirees will not have to enroll in the Medicare drug benefit nor face a late enrollment fee in the form of a higher premium if they enroll at a later date.

If CMS determines a plan is not as good as the Part D benefit and hence not eligible for the subsidy, retirees have three options:

- Retain coverage under the current employer/union plan AND enroll in Part D by May 15, 2006 in order to get the prescription drug benefit as well as avoid a late enrollment fee. CMS estimates 1.7 million retirees will enroll in a PDP and receive either additional coverage or financial help from their employer/union;
- Keep current coverage and not enroll in Part D. However, retirees will be subject to the increase in premiums for late enrollment if they join later;
- Drop current coverage and enroll in a PDP. If a retiree does this, the ability to revert to employer/union coverage later is unlikely.

Before making any of the above decisions, retirees should contact their benefits administrator and make sure they understand their current drug coverage.

Medigap plans are private insurance plans that supplement Medicare. Only three of the ten standardized plans offer prescription drug coverage. Those currently enrolled will be able to continue with their Medigap plan for drug coverage but the plans are not available for new enrollees after January 1, 2006. Most Medigap coverage is not as good as the Medicare basic benefit. ***Persons enrolled in a Medigap plan with drug coverage will be notified by their insurance company in the fall of 2005 whether their Medigap plan meets Medicare standards.*** If not, the individual can enroll in a PDP and still have Medigap without drug coverage. Individuals who keep their Medigap plan with drug coverage that is not as good as Medicare will be subject to the increase in premiums for late enrollment if they join a Part D plan later.

Medicare Advantage is the new name for Medicare+Choice, the managed care Part C program in Medicare. It allows private companies, primarily HMOs and PPOs, to offer a managed care health plan to Medicare eligible beneficiaries. MA plans that include prescription drug coverage

are Medicare Advantage Prescription Drug (MA-PD) plans. Participating MA-PD plans will automatically enroll their current plan participants. New and expanded MA-PDs will begin marketing their plans to other Medicare beneficiaries in October, 2005. **Persons enrolled in a MA-PD should review materials from their plan carefully as coverage may change; they can select another plan.**

State Pharmaceutical Assistance Programs (SPAPs) are programs that many states operate to provide drug coverage to residents with limited income. SPAPs may supplement the new Medicare prescription drug coverage for certain individuals. **Those currently receiving assistance with their drug costs from their SPAP should inquire whether or how their state program intends to continue assistance.**

Most important, it is possible that none of the plans offered will cover all the drugs an individual needs.

Veterans Administration (VA) and TRICARE. Veterans and military retirees who get their health care benefits from the VA or TRICARE already have coverage that is at least as good as the Medicare prescription drug plan and they should keep that coverage.

Choosing A Plan

Beneficiaries who are not automatically assigned and enrolled, nor covered by an existing plan that will continue, will have to make three basic decisions in order to obtain prescription drug coverage.

First, individuals must choose whether to apply for the benefit at all. Those who have low drug costs may find that it is more costly to join a plan. However, they will take a chance on a higher premium of at least 1 percent per month for every month they wait to enroll after the initial enrollment period ends on May 15, 2006.

Second, there is the choice of type of plan-whether to apply for the benefit either through a stand-alone drug plan or a Medicare Advantage managed care plan with prescription drug coverage.

Third, those who want drug coverage will have to choose from among plans available where they live. In some regions, there will be just two plans and the choice may be relatively easy. Others, however, may have to compare and select from a number of plans that could vary substantially on generic and brand name drugs covered, premiums and co-payments. Plans will also have their own pharmacy networks, which means that not all pharmacies will be able to fill prescriptions. Comparing several plans and their features will likely be very difficult. Most important, it is possible that none of the plans offered will cover all the drugs an individual needs.

For Information and Help With Plan Choice and Enrollment:

Beneficiaries should compare plans based on their prescription needs. Information and applications from approved plans and also from CMS will be available in October 2005. The following agencies will be available to assist with applications. To find the nearest office, beneficiaries should consult their local telephone book or go to the web sites listed below:

- Phone enrollment through 1-800-Medicare (800-633-4227; TTY 877-486-2048) beginning in October.
- Internet enrollment at www.medicare.gov beginning mid-October.
- Counseling and enrollment at on-site locations such as community-based organizations and area agencies on aging. www.shiptalk.org, click "Find a Counselor" for one in your area.
- State Health Insurance Counseling Programs (SHIPS). www.shiptalk.org

Endnotes

[1] In addition to the expenditures for the prescription drug benefit, beneficiaries will also see an increase in the Medicare Part B premium from $78.20 in 2005 to $89.20 in 2006 and a continued increase in the Part B deductible, which is $110 in 2005.
[2] Maps of the MA and PD regions can be found at: www.cms.hhs.gov/medicarereform/mmaregions. Final rules may also be obtained at the CMS website. Note that the documents are very long.
[3] Many retirees have prescription drug coverage from an employer or their union. The options and process for both employers and unions are the same and are combined here for ease of explanation.
[4] Employers include non-profit organizations as well as commercial businesses.
[5] "Creditable" is the term used by the Centers for Medicare & Medicaid Services in its determination of whether employer/union/ Medigap plans are as good as the standard Part D drug benefit.
[6] This is equivalent to $891 for plan sponsors with a 25 percent marginal tax rate, and $1,028 for plan sponsors with a 35 percent marginal tax rate.

Glossary of Key Terms

Centers for Medicare & Medicaid Services (CMS). The federal agency that administers the Medicare and Medicaid programs and responsible for implementation of MMA.

Creditable. Determination by CMS of employer/union status as qualified to receive the retiree drug subsidy. Also, CMS determination of Medigap plans that provide prescription drug coverage as good as the Part D benefit.

Deemed Eligible. Determination by CMS of those who already qualify for the low-income subsidy and do not need to apply for it.

Dual Eligibles. Individuals who are beneficiaries of both the Medicare and Medicaid programs.

Formulary. List of drugs approved for use or payment-in other words, covered or reimbursable drugs.

Health Maintenance Organization (HMO). Managed care plan primarily owned and operated by insurers that acts as both the insurer and the provider of health care services to an enrolled population.

Managed Care Plan/Organization. A plan/organization that provides a range of services in exchange for a per capita payment.

Medicare Savings Program. A part of state Medicaid programs that pays Medicare premiums, and in some cases, Medicare deductibles and coinsurance for three categories of low-income Medicare beneficiaries: Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), and Qualified Individual (QI).

Medicare Advantage (MA, formerly Medicare+Choice). Part C in the Medicare program allows private companies to offer a managed care health plan to Medicare eligible beneficiaries. MA plans may offer prescription drug coverage through a Medicare Advantage Prescription Drug Plan (MA-PD).

Medigap Plans. Private supplemental insurance plans designed to cover gaps in the Medicare program. There are 10 standardized policies labeled Plan A through Plan J. Only Plans H through J offer a prescription drug benefit; but the drug coverage offered through these plans will not be available after January 1, 2006.

Preferred Provider Organization (PPO). Network of doctors and hospitals that contract with an insurer to provide health care on a fee-for-service basis at lower rates for those enrolled.

Private Fee-For-Service (PFFS). Plan that covers enrollees through a private indemnity health insurance policy.

Stand Alone Prescription Drug Plan (PDP). Private plans that offer just a drug benefit.

Alliance for Retired Americans Position on MMA

The Alliance opposed passage of the 2003 Medicare prescription drug law for four major reasons:

- The benefit is not comprehensive—beneficiaries will have to pay high-out-of-pocket costs for the benefit which will increase nearly 80 percent over the first 8 years alone;
- The law does too much to dismantle traditional Medicare in favor of private health plans, which stand to gain billions in government subsidies;
- The law does nothing to control the escalating increases in drug prices and expressly prohibits Medicare from using its buying power to negotiate lower drug costs; and
- There is a possibility that employer-sponsored health benefits more generous than the Medicare drug benefit may end coverage.

This is the third in a series of issue briefs from the Alliance for Retired Americans Educational Fund on issues and programs that should be considered at the White House Conference on Aging scheduled for October 23-26, 2005 in Washington, D.C.

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Issue Brief

Medicare Rx Drug Benefit: Navigating Low-Income Assistance

No.4 | June 2005

Introduction

Under the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, all Medicare beneficiaries who have Medicare Part A (Hospital Insurance) or Part B (Medical Insurance for doctor services and outpatient care) will have access to prescription drug benefits. Most individuals will obtain drug coverage through private plans, either a stand-alone prescription drug plan (PDP) offered by an insurance company or through a Medicare Advantage plan with prescription drug coverage (MA-PD) (See Glossary, page 6.)

This report provides basic information for low-income beneficiaries, their families and their advocates about the application process for assistance and enrollment.[1] The May 2005 issue brief from the Alliance for Retired Americans Educational Fund (ARAEF), *Medicare Prescription Drug Benefit: A Guide Through the Maze*, offers guidance for other Medicare beneficiaries eligible for the drug benefit but not the subsidized help.

Applying for Assistance

The Centers for Medicare & Medicaid Services (CMS), the agency responsible for implementation of MMA, will provide many low-income Medicare recipients with subsidy assistance for their prescription drug costs when the Medicare drug benefit begins on January 1, 2006. The amount of assistance will depend on factors such as their Medicaid status, income and assets, and living arrangement. The classification breakdown and extent of assistance with drug costs are summarized in the chart on page 3.

The low-income subsidy (LIS) helps pay the premiums, deductible, and co-payments for the new drug benefit. It also closes the coverage gap for low-income individuals.[2] Many low-income individuals will have to apply and qualify for the assistance first, then enroll in a plan at a later date. Others will automatically qualify for assistance and will be automatically enrolled. All eligible low-income beneficiaries will receive the subsidy only after enrollment.

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[1] The Centers for Medicare & Medicaid Services officials estimate 11 million of the nearly 14 million Medicare beneficiaries eligible for the low-income subsidy will enroll in 2006. The Congressional Budget Office projects 8.7 million.

[2] The "coverage gap" or "doughnut hole" refers to the break in prescription drug coverage when total costs (both the individual's out-of- pocket drug costs and the costs paid by the drug plan) fall between $2,251 and $5,100. It is between these amounts that most beneficiaries have to pay for 100 percent of their drug costs. It is only after reaching $3,600 in total out-of-pocket expenditures, including the deductible or the $5,100 catastrophic threshold, that coverage resumes.

I. Automatic Eligibility and Enrollment

The following beneficiaries do not have to apply for the subsidy because they are "deemed eligible" or automatically entitled (see Glossary).

Dual Eligibles

Approximately 6.4 million Medicare beneficiaries are termed "dual eligibles," meaning they have both Medicare and full Medicaid benefits. This group is in a vulnerable position since they will lose the prescription drug coverage that Medicaid currently provides for them. They could pay more in cost-sharing when the Medicare benefit takes effect. Under the MMA, they will pay $1-2 for a generic and $3-$5 for a brand-name drug, depending on their income. Cost-sharing[3] is projected to increase in subsequent years due to drug price inflation.

Dual eligibles will automatically qualify for the assistance; they do not have to apply for it. However, in order to receive the benefit they must enroll in a private plan, either a stand-alone prescription drug plan plan offered by an insurance company or a Medicare Advantage plan that offers both prescription drug and health coverage. If they do not choose a plan, the CMS will assign them to a prescription drug plan beginning in October 2005. They can switch to another plan at any time even after the benefit takes effect January 1, 2006.

Many nursing home residents fall within the dual eligible category—one in four dual eligibles lives in a nursing home or other long-term care facility.[4] This population is exempt from any cost-sharing. They will pay no premiums, no deductibles, no coinsurance, and no co-payments.

There are special concerns with the "dual" population because they tend to be poorer and sicker than other Medicare recipients. Seven in 10 dual eligibles have incomes below $10,000. They have higher rates of Alzheimer's disease, diabetes, pulmonary disease and stroke. Forty percent have disabilities, and nearly four in 10 have a mental or cognitive impairment.[5]

Plans must cover at least two drugs in each therapeutic category and class, but they do not have to cover every drug. Thus, beneficiaries may not have coverage for all of the drugs they require.[6] They will need help determining the best plan to cover most of their drugs and also to find a pharmacy that is part of the plan's network.

***Example**: Ms. Smith is a nursing home resident who is enrolled in both Medicare and Medicaid. Medicaid currently pays for most of her care as well as her prescription drugs. Under the MMA, she is automatically eligible for low-income assistance and will not have to pay anything for her prescription drugs. Medicaid will continue to pay for her other long-term care services but not her prescription drugs. Her sister, Ms. Jones, is also on Medicaid as well as Medicare but lives at home. She will be automatically eligible for the subsidy and automatically enrolled in a prescription drug plan, but she will pay between $1-2 per prescription for a generic drug and $3-5 for a brand-name drug. Both may find they do not have coverage for all of the medications they need.*

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[3]Cost-sharing means consumers pay a portion or percentage of the price. Co-payments are a consumer's payments of a fixed cost per prescription (for example, $2); co-insurance is payment of a proportion of costs (for example, 25 percent).

[4] Medicare Rights Center. Disenrollment Problems Foreshadow Catastrophic Transition Problems for Medicare Drug Benefit. May 5, 2005.

[5] Medicare Rights Center. Eliminate Asset Tests for the Low-Income Subsidy and Medicare Savings Program. May 19, 2005.

[6] The auto-enrollment by CMS will be random and not based on prescription needs.

SSI and Medicare Savings Program

Current Supplemental Security Income (SSI) and Medicare Savings Program (MSP) beneficiaries—Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB) and Qualified Individual (QI) – who do not have full Medicaid are also considered "deemed eligible." (See Glossary). CMS will auto-enroll SSI and MSP beneficiaries who do not choose a plan by May 2006.

***Example**: Mr. Johnson is a Medicare beneficiary. He is not on Medicaid but because his annual income is $9,000, and he has limited resources, his state Medicaid agency pays for his Medicare cost-sharing expenses through the Qualified Medicare Beneficiary Program. He does not have to apply for the subsidy but he should enroll in a plan. If he does not choose a plan, CMS will put him in a plan automatically in May 2006. In 2006, he will pay no premium or deductible for his drug benefit and will have no gap in coverage. He will pay $2 for a generic drug or $5 for a brand-name prescription drug.*

Table 1. Medicare Drug Benefit for Eligible Low-Income Individuals

Low-Income Subsidy Level	Monthly Premium	Annual Deductible	Cost-Sharing	Coverage Gap
Dual Eligibles living in nursing home	None	None	None	None
Other Dual Eligibles	None	None	$1-2/generic $3-5/brand no co-pays after $5,100 total drug costs	None
SSI, MSP and those with income less than 135% federal poverty level ($12,920/ individual in 2005) and **assets** less than $6,000/individual; $9,000/couple	None	None	$2/generic, $5/brand no co-pays after $5,100 total drug costs	None
Income 135%-150% federal poverty level ($12,920-$14,355/individual in 2005) and **assets** less than $10,000/ individual; $20,000 couple	Sliding scale up to $35	$50	15% of total costs up to $5,100 threshold; $2/ generic, $5/brand thereafter	None

II. Eligibility for Other Low-Income Individuals

Low-income individuals who are not deemed eligible may qualify for the low-income subsidy if their incomes are less than 150 percent of the federal poverty level (FPL). Their assets must not be more than $10,000 for an individual and $20,000 for a couple. From May through mid-August 2005, they will receive a notice of possible eligibility from the Social Security Administration (SSA).[7] The SSA and state Medicaid offices are responsible for processing eligibility determinations and began taking applications starting in June 2005.

To qualify for the low-income subsidy, beneficiaries will have to meet both an income and assets test. Assets include checking and savings accounts, investments, and life insurance; applicants will need to supply this information. Not included are the value of a house, automobile, burial plot, nor household furnishings and possessions. Nearly 14 million non-institutionalized people with Medicare would qualify for the LIS drug benefits on income alone. However, an estimated 2.4 million will not qualify for the subsidy because of the assets test.[8]

Once approved for the subsidy, individuals must choose and enroll in a plan—they will not be automatically enrolled. Enrollment is a two-step process separated by several months. Many people may forget to enroll because of a four-month lag between signing up for the subsidy in July 2005 and enrolling in a plan in November.

For Information and Help with Applying for Low-Income Subsidy

Beneficiaries who may be eligible for a subsidy must apply and provide information about their income and assets. The following agencies will be available to assist with applications. To find the nearest office, consult your local telephone book or go to the web sites listed below.

- Social Security Administration field offices. 1-800-772-1213 (TTY 1-800-325-0778) www.socialsecurity.gov
- State Medicaid offices. www.cms.hhs.gov/medicaid/statemap.asp
- State Health Insurance Counseling Programs (SHIPs). www.shiptalk.org
- Area Agencies on Aging (AAAs) and local community organizations. www.shiptalk.org, click on "Find a Counselor," select location.

***Example**: Mr. Brown's income is $13,500. His checking and savings accounts about to less than $10,000 and he has no investments nor life insurance. He receives a notice in May 2005 from the Social Security Administration informing him that he may be eligible for help paying his prescription drug costs. He applies for the subsidy at the local SSA office and learns in July that he is eligible. He doesn't understand that he must enroll in a plan in mid-November*

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[7] See ARAEF May 2005 issue brief, *Medicare Prescription Drug Benefit: A Guide Through the Maze,* for calendar showing the approximate timeline for continuing implementation of the benefit from May 2005 through the enrollment deadline of May 2006.
[8] Kaiser Family Foundation. Low-Income Subsidies for the Medicare Prescription Drug Benefit: The Impact of the Asset Test. April 2005.

and does nothing. In January 2006, he finds out that he does not have drug coverage because he is not in a plan. He may still enroll before the end of the enrollment period on May 15, 2006. When he does, he will pay a monthly sliding scale premium of about $18.50, an annual $50 deductible, and 15 percent of his drug costs up to $5,100.

There is an advantage to applying for the subsidy through the state Medicaid agency rather than the SSA office. State Medicaid programs, unlike SSA offices, must also screen applicants for the Medicare Savings Program. Under MSP, beneficiaries receive help from their state which pays for their Medicare Part B premiums and, in some cases, their Medicare deductibles and co-insurance. Some states also have more generous MSP eligibility criteria than the subsidy criteria. For example, they may not count any resource or they may exclude more income. People who apply through the state Medicaid agency and are found eligible for MSP using the more generous MSP criteria will automatically be eligible for the subsidy, but if they had applied for the subsidy at SSA they might not have been found eligible.

Role of States

Many states operate State Pharmaceutical Assistance Programs (SPAPs) to provide drug coverage to residents with limited income. For certain individuals, SPAPs may complement the new Medicare prescription drug coverage by paying their cost-sharing or providing coverage for some drugs that are not on a plan's formulary. **Those currently receiving assistance with their drug costs from their SPAP should inquire whether or how their state program intends to continue assistance.**

To ease the transition, states have the option to allow dual eligible beneficiaries to fill three months' worth of their prescriptions in December prior to losing their Medicaid coverage. States will also be primarily responsible for educating and counseling recipients.

Choosing and Enrolling in a Plan

Those who are eligible for the subsidy must enroll in a plan to receive the benefit. CMS will auto-enroll those who are "deemed eligible," but others must choose a plan. At press time, there are many unknowns. The identity of plan sponsors and details of their plans such as the formulary or covered drugs, premiums, co-payments and their pharmacy network will not be available to beneficiaries until the fall of 2005.

When the information becomes available, beneficiaries will have to decide which plan best addresses their medication needs. If LIS beneficiaries cannot find a plan that includes every one of their drugs, they may be unable to pay all the costs for the uncovered drugs.

Conclusion

The MMA makes monumental changes to Medicare. Private insurers have a major role in providing drug benefits to Medicare beneficiaries, introducing an array of choices. Medicare beneficiaries may find that selecting one of several plans, each with a different formulary and pharmacy network, will be too overwhelming and do nothing.

Low-income beneficiaries are more vulnerable because they are generally more physically and cognitively impaired than other Medicare beneficiaries. Low-income individuals and their families will likely need extensive one-on-one counseling to understand their options for accessing the benefit.

Glossary of Key Terms

Centers for Medicare & Medicaid Services (CMS). The federal agency that administers Medicare and Medicaid and is responsible for implementating MMA.

Deemed Eligible. CMS determination of those who already qualify for the low-income subsidy and do not need to apply for it.

Dual Eligibles. Individuals who are beneficiaries of both the Medicare and Medicaid programs. They receive full Medicaid benefits. Their prescription drugs have been provided through Medicaid.

Formulary. List of drugs approved for use or payment—in other words, covered or reimbursable drugs.

Low-Income Subsidy (LIS) Program. Assistance with drug costs provided to low-income beneficiaries under the MMA. LIS beneficiaries must meet income and asset criteria and enroll in a plan to receive the LIS benefit.

Medicaid. A jointly funded federal-state program providing health coverage for low-income individuals who meet income, asset and categorical eligibility criteria.

Medicare Advantage (MA, formerly Medicare+Choice). Part C in the Medicare program allows private companies to offer a managed care health plan to Medicare eligible beneficiaries. MA plans may offer prescription drug coverage through a Medicare Advantage Prescription Drug Plan (MA-PD).

Medicare Savings Program (MSP). A part of state Medicaid programs that pays Medicare premiums, and in some cases, Medicare deductibles and coinsurance for three categories of low-income Medicare beneficiaries: Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), and Qualified Individual (QI).

Qualified Individual (QI). Individual eligible for Medicare Part A who has income between 120 and 135 percent of poverty and whose resources do not exceed a certain level (twice the level allowed under SSI). With a 100 percent federally matched grant, state Medicaid agencies pay the cost of Medicare Part B premiums. In contrast to the SLMBs, this program is not an entitlement.

Qualified Medicare Beneficiary (QMB). An individual eligible for Medicare Part A who has income at or below the federal poverty level and whose resources do not exceed a certain level. States, through their Medicaid agencies, are required to pay the Medicare cost-sharing for these individuals including Medicare premiums, and some or all of the deductibles and co-insurance.

Specified Low-Income Medicare Beneficiary (SLMB). An individual eligible for Medicare Part A who has income between 100 and 120 percent of the federal poverty level and whose resources do not exceed a certain level. State Medicaid agencies are required to pay the cost of Medicare Part B premiums for these individuals.

Supplemental Security Income (SSI). A federal income support program for low-income disabled, aged, or blind individuals. The maximum federal benefit rate is 27.4 percent below the official poverty level. Eligibility for SSI usually makes a person automatically eligible for Medicaid.

Stand Alone Prescription Drug Plan (PDP). Private plans that offer just a drug benefit.

Alliance for Retired Americans Position on MMA

The Alliance opposed passage of the 2003 Medicare prescription drug law for four major reasons:

- The benefit is not comprehensive—beneficiaries will have to pay high-out-of-pocket costs for the benefit which will increase nearly 80 percent over the first 8 years alone;
- The law does too much to dismantle traditional Medicare in favor of private health plans, which stand to gain billions in government subsidies;
- The law does nothing to control the escalating increases in drug prices and expressly prohibits Medicare from using its buying power to negotiate lower drug costs; and
- There is a possibility that employer-sponsored health benefits more generous than the Medicare drug benefit may end coverage.

This is the fourth in a series of issue briefs from the Alliance for Retired Americans Educational Fund on issues and programs that should be considered at the White House Conference on Aging scheduled for December 11-14, 2005 in Washington, D.C.

This report was researched and written by Dianna M. Porter, director for policy. ARAEF gratefully acknowledges Vicki Gottlich, Center for Medicare Advocacy, for her review and comments. This is a publication of the Alliance for Retired Americans Educational Fund (ARAEF), the research and education branch of the Alliance for Retired Americans. ARAEF is a 501(c)(3) organization that focuses primarily on retiree issues.

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Issue Brief

Alliance for Retired Americans
EDUCATIONAL FUND

Retiring Into Work

No.5 | July 2005

Introduction

Working in later life often supplements other sources of retirement income, such as Social Security, pensions and savings, and it is likely to become even more important in the future. While many mid-life workers say they would like or need to continue working past normal retirement age, policy makers and employers are examining ways to encourage them to remain in the labor force.

This report explores the advantages and disadvantages of working longer and the practices that can encourage continued participation in the labor force at older ages.

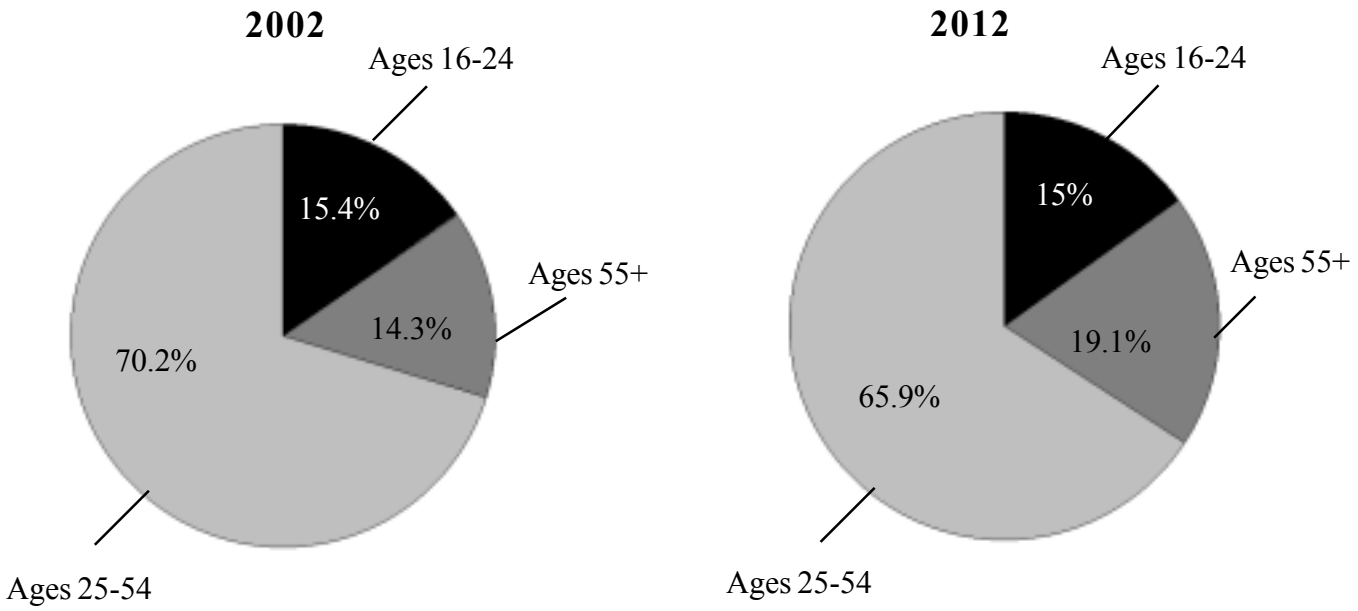
To Work or Not to Work

Much is being written about the aging population in the United States, particularly as the "baby boom" population nears retirement.[1] Policy makers and employers are exploring ways to encourage workers to delay retirement, which could produce societal and economic benefits. If baby boomers work longer, they will consume more products, add to national productivity, continue paying income and payroll taxes and contribute to economic growth. They will also have more time to save money for retirement.

Labor Force Trends

Over the next two decades, the labor force participation rate for older workers age 55 and over is expected to increase, largely due to the baby boom generation. In fact, the labor force rate for workers age 55 and over is expected to increase four times that of the overall labor force in the next several years. In 2002, the 55+ population made up 27.6 percent of the total U.S. population and one in every seven (14.3 percent) workers. By 2012—when baby boomers will be ages 48-66—women and men age 55 and older will account for one-third of the population (32.4 percent) and nearly one in five workers (19.1 percent). Over the same time, the proportion of workers ages 25-54 is expected to decline from 70.2 percent of the workforce in 2002 to 65.9 percent in 2012. The median age of the labor force is projected to be 41.4 years in 2012, nearly 7 years higher than in 1982.[2]

Figure 1. Distribution of U.S. Workforce by Age, 2002 and Projected 2012



Source: Toossi, Mitra. "Labor force projections to 2012:the graying of the U.S. workforce." Monthly Labor Review. February 2004.

The gender gap in labor force participation rates has been shrinking. The labor force participation rate for women overall continues to increase steadily, rising from 52.6 percent in 1982 to 59.6 percent in 2002; it is projected to be 61.6 percent in 2012. The labor force participation rate of women ages 55 to 64 years has risen more dramatically, from 41.8 percent in 1982 to 55.2 percent in 2002 and to a projected 60.6 percent in 2012.[3]

Despite higher participation rates of older workers and women, labor force growth overall will slow by almost half over the next 10 years. This could create a shortage of up to 10 million workers by 2010 that would indicate a need for the continued involvement of older workers in the labor force.[4] By 2030 the population over age 65 will be double what it is today. Continued labor shortages are anticipated because the generation following the boomers is substantially fewer in numbers due largely to a decline in the fertility rate since the 1970s.[5]

Aspirations of Older Workers

What do mid-life and older workers want? Doing work that they enjoy, that enables them to remain active and productive and helps others are key factors. Many say that they want or need to continue working after normal retirement. One survey of baby boomers found that 79 percent plan to work during their retirement years. Of those, 15 percent plan to start a business and 7 percent plan to work full-time at a new job; 30 percent plan to work part-time for enjoyment and 25 percent part-time for needed income.[6]

In another survey of workers between ages 50 and 70, half report that they want jobs both now and in retirement that help improve the quality of life in their communities. Seven in 10 of those ages 50-59—the advance wave of baby boomers—are interested in retail "and good work" jobs in education and social services.[7] Another study of workers age 50 and over found approximately half said the desire to stay mentally and physically active and the desire to remain productive or useful were major reasons to work in retirement.[8]

Many who plan to work, however, will not. Not all workers will be able to continue to work in later life. Physical and mental health, lack of health insurance, job stress, transportation, employment status of a spouse and caregiving responsibilities are among the many factors that may influence the decision to retire completely. The lack of employer-provided health insurance for workers increases the average retirement age by two years for women and 1.5 years for men.[9]

Conversely, economic pressures may produce a negative motivation to continue working. Seventy-six percent of workers ages 50 to 65 who plan to continue working after age 65 identify the need for money as a major reason to work in retirement. [10]

As the following table illustrates, the factors affecting the decision to work in retirement are complex as are the obstacles.

Looking Beyond Normal Retirement Age

Reasons to Continue Working	Reasons to Retire
Positive Reasons: Have a phased retirement option; flexible schedule Enjoy one's work and associations Challenge and engagement	**Positive Reasons**: Spouse is retired Preference for leisure and creative activities Availability of defined benefit pension Availability of Social Security benefits Eligible for Medicare
Negative Reasons: Need the income Loss of anticipated retirement savings, stock market losses Loss of or increased cost-sharing for retiree health coverage Lack of or insufficient pension benefits and savings	**Negative Reasons**: Poor health Age discrimination Lack of new training opportunities Lack of flexible schedules Caregiving responsibilities Job stress Job loss—layoffs, employer bankruptcy Lack of employer-provided health coverage

Despite the Age Discrimination in Employment Act of 1967, which prohibits workplace discrimination against persons age 40 and older, the "silver ceiling," where age discrimination prevents continued employment or advancement, still exists. A survey of human resource managers found that 59 percent do not actively recruit older workers and 65 percent do not do anything specific to retain older workers.[11] Federal and state age discrimination laws need to be strengthened and vigorously enforced while workers' awareness of their employment rights should be improved. No one should be denied a job, laid-off or passed over for opportunities because of their age.

No one should be denied a job, laid-off or passed over for opportunities because of their age.

Workers over age 50 are less likely to be tapped for formal training to upgrade job skills.[12] Increasing education and training opportunities for older as well as younger workers may be one of the best investments employers can make. For example, United Technologies Corp. spends more than $60 million annually on its employee scholar program, which pays the costs of workers of any age who study in their spare time. The company estimates that retention rates among its "employee scholars" are about 20 percent higher than U.S. workers as a whole.[13]

Many older workers who want to continue working also wish to work fewer hours in "phased retirement," either on a flexible part-time schedule with a current employer or part-time with a new employer.[14] In a study of workers and retirees, nearly two in five workers (38 percent) ages 50 and over express interest in phased retirement, and nearly four in five of the 38 percent say that the availability of phased retirement would encourage them to stay in the workforce longer. One-third (33 percent) of retirees said a phased retirement plan would have prompted them to remain in the workforce longer. The most attractive aspects of phased retirement are the ability to reduce work hours and possibly access pension benefits as long as final pension benefits after full retirement are not reduced.[15]

Policies and Regulations

Some policy proposals to prolong work life are actually disincentives to retire rather than incentives to work. Such proposals include increasing the age for full Social Security benefits beyond age 67,[16] increasing the early Social Security retirement age of 62, and indexing the Social Security eligibility age for benefits to increases in life expectancy.

These approaches have numerous drawbacks. Increasing the early or normal retirement age fairly is difficult among a diverse population with different occupations, educational levels, health conditions and gender and ethnicity life expectancies. Those who promote such

increases maintain that few workers today are in physically demanding jobs and thus can work longer.

Blue-collar and service sector jobs can be physically demanding. The decline in physical job demands over the past decade is confined largely to college graduates. While two out of five workers ages 55 to 60 reported in 2002 that their jobs almost never require much physical effort, one in five report that their jobs almost always require substantial physical effort.[17] The average age of workers in some manufacturing jobs is 50 or older.[18] Those in physically demanding jobs suffer more from health problems that complicate their ability to remain in the labor force. Consequently, many of these workers will be unable to continue working to a later age.

Physical work is not the only source of stress. While highly educated workers are less likely to do physical labor, these white-collar jobs increasingly require intense concentration, skill in dealing with other people and good eyesight, thereby becoming more difficult and stressful for older workers.[19]

Many workers cannot envision employers hiring them if the normal retirement age were raised to 69 or 70.

Many workers cannot envision employers hiring them if the normal retirement age were raised to 69 or 70.[20] Raising the age higher than scheduled under current law would likely mean more people would retire earlier.

A policy change that ties Social Security benefits to longevity places the burden of that change entirely on the older persons affected by it. The percentage of pre-retirement earnings replaced by benefits would steadily decline. Some may be able to adjust to it but many others will not. Older women in particular, who live longer and poorer than men, would be greatly burdened from such a policy.

Some regulatory changes, however, can help workers with a defined benefit (DB) pension plan work longer. Most pension plans are either defined benefit or defined contribution (DC) plans.[21] In a DB plan, the employer promises a benefit amount that is usually determined by salary and length of service. In a DC plan, such as a 401(k) plan, employees and/or employers make specific contributions to an investment account; the benefits depend on investment performance.[22] Employee Retirement Income Security Act (ERISA) regulations currently prevent workers with a DB plan from collecting their pensions while continuing to work for the plan sponsor. DC plans have fewer regulatory restrictions and allow participants to make withdrawals at age 59 ½ while they are still working. Changing the ERISA regulations may encourage employers to offer phased retirement and allow employees to accrue retirement pension credits or collect benefits while working reduced hours. The Treasury Department and the Internal Revenue Service have proposed rules, effective in 2006, to allow workers over

age 59½ to receive a portion of their defined benefit pensions and continue working as long as they scale back their work at least 20 percent.

Low-income older Americans, particularly those in rural areas, face multiple barriers to employment, including limited job and training options, isolation and scarce transportation. The Senior Community Service Employment Program (SCSEP) under the Older Americans Act (OAA) provides part-time employment opportunities for older Americans who are economically disadvantaged, have significant barriers to employment and need intensive services. This program, however, has been flat-funded for several years. The OAA is due for reauthorization in 2005, which provides Congress with the opportunity to improve and expand this popular program with additional funding.

Employer Adaptations

Employees who are willing to work longer report that flexible schedules, job sharing, flex-place, part-year and other non-traditional work arrangements are important. Employers should adapt to these changing expectations accordingly if they want to retain older workers. They can remove barriers older workers face when seeking and retaining employment; barriers include employer attitudes about older workers' productivity.

Modest investment in job modification and workplace redesign, such as in the programs described below, can meet many of the workplace needs of older workers.[23]

Employer Initiatives to Support Older Workers

Health professionals, particularly nurses, are in short supply. In addition to increased public support for education, employers in the health field can offer programs to support the maturing workforce such as offering health care services at a discount. For example, St. Mary's Medical Center of Huntington, W est Virginia, provides many diagnostic and preventive services free to mature female employees (screening for breast cancer, skin cancer and cervical exams), as well as a range of services to all employees such as free annual check ups. The Center also adjusts pension calculations to allow workers to reduce hours in their final years of employment without decreasing their final pension benefit. This allows older workers to cut down on their hours without risking loss of retirement benefits.

Charles Stark Draper Laboratory in Cambridge, Massachusetts, an applied research, engineering, and technology company offers a recruitment program for retired and former employees; a generous tuition program for graduate and undergraduate college work; a choice of defined benefit, defined contribution, and cash balance retirement plans; and on-site seminars in retirement planning. Forty-two percent of the company's employees are over age 50.

Source: AARP. "Staying Ahead of the Curve 2004: Employer Best Practices for Mature Workers." (August 31, 2004)

Employers can also initiate dependent care programs, including respite care, for employees who have caregiving responsibilities.

Conclusion

There are many ways in which older persons can be encouraged to lead more productive, healthier and more enjoyable lives by remaining in the workforce longer than the normal retirement age.

Working longer than the normal retirement age is an option for greater income security in later life. However, that option should be voluntary, only if the individual wants to do so. The emphasis should be on developing policies and practices that enable people to work longer if they choose, not policies that inflict an onerous burden on older workers. Mandatory policies that discourage retirement cannot readily adapt to diversity and in the end will be an inequitable imposition on many.

Endnotes

[1] The estimated 77 million baby boomers are those born between 1946 and 1964. In 2005, they are between ages 41-59.
[2] Toossi, Mitra. "Labor force projections to 2012: the graying of the U.S. workforce." Monthly Labor Review. Bureau of Labor Statistics. February 2004.
[3] Ibid.
[4] Congressional Budget Office. U.S. Bureau of Labor Statistics.
[5] The lower fertility rate of 2 children per woman of childbearing age is referred to as the "baby boom bust."
[6] AARP. Baby Boomers Envision Retirement II-Key Findings. May 2004.
[7] MetLife Foundation/Civic Ventures. "New Face of Work Study." June 2005.
[8] Brown, S. Kathi. "Attitudes of Individuals 50 and Older Toward Phased Retirement." AARP. March 2005.
[9] Porter, Eduardo, and Mary Williams Walsh. "Retirement Turns into a Rest Stop as Benefits Dwindle." New York Times. February 9, 2005.
[10] Brown, S. Kathi. op.cit.
[11] Business Week. "Old. Smart. Productive." June 27, 2005.
[12] Kleyman, Paul. "Boomers to Redefine Workplace." Aging Today. Nov-Dec 2004.
[13] Business Week. June 27, 2005.
[14] Rix, Sara E. "Aging and Work: A View from the United States." AARP Public Policy Institute. February 2004.
[15] Brown, S. Kathi. op.cit
[16] The full eligibility age, or normal retirement age, for Social Security benefits is being raised from 65 to 67 from 2000 to 2022. In 2005, the eligibility age for full Social Security benefits is 65 years and 6 months.
[17] Johnson, Richard W. "Trends in job demands among older workers, 1991-2002." Monthly Labor Review. July 2004.
[18] U.S. General Accounting Office. "Workforce Challenges and Opportunities for the 21st Century: Changing Labor Force Dynamics and the Role of Government Policies." June 2004.
[19] Johnson, Richard W. op.cit.
[20] Tierney, John. "The Adams Principle." *New York Times*. June 21, 2005.
[21] Some employers have initiated or converted to cash balance plans which are a hybrid of DB and DC plans. Cash balance plans are DB plans with DC features including an individual account with potential portability from one job to another. Conversions may hurt older workers.
[22] DB plans are insured by the Pension Benefit Guaranty Corporation up to certain limits; DC plans are not.
[23] AARP. "Staying Ahead of the Curve 2004: Employer Best Practices for Mature Workers." August 31, 2004.

This is the fifth in a series of issue briefs from the Alliance for Retired Americans Educational Fund on issues and programs that should be considered at the White House Conference on Aging scheduled for December 11-14, 2005 in Washington, D.C.

This report was researched and written by Dianna M. Porter, director for policy. ARAEF gratefully acknowledges Marilyn Park, AFL-CIO, and Sara Rix, AARP, for their reviews and comments.

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Issue Brief

Alliance for Retired Americans
EDUCATIONAL FUND

An Affordable Home of One's Own

No.6 | August 2005

Introduction

As individuals age, their need for suitable, affordable, quality housing is increasingly important. However, whether they rent or own their home, most older adults have increasing difficulty finding or maintaining housing that meets their changing housing needs as they age and fits within their financial means.

Unfortunately, as the need for affordable housing rises, particularly with a growing older population, funding for federally assisted housing programs has been flat for more than two decades. The supply of affordable housing is further depleted as owners of federally subsidized properties convert their units to the private market.

This report examines the housing needs of America's seniors, the status of federal housing programs, and what actions may be taken on the federal, state and local levels to address what the recent Congressionally-established Seniors Commission characterized as a "quiet crisis in America."[1]

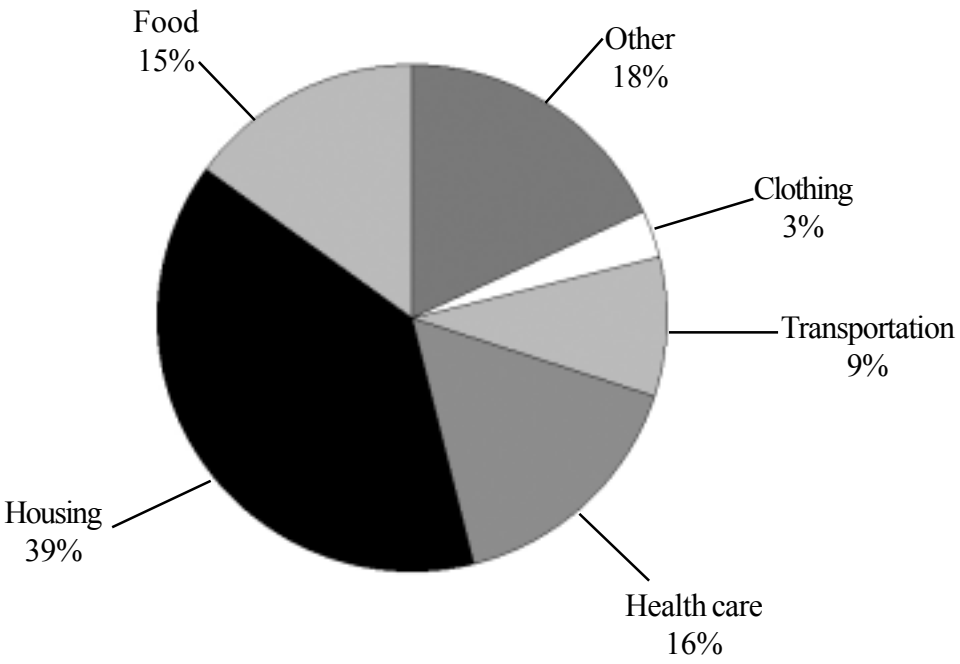
Housing Needs of Older Americans

More than seven million older households are having difficulty paying for housing or are living in physically substandard dwellings. By 2030, with decreased investment in housing and the aging of the baby boom population, that number is projected to rise to 11.3 million.[2]

Most senior households, whether homeowners or renters, are spending more than 30 percent of their income on housing, which goes beyond what is considered affordable.[3] Both married and unmarried adults over age 65 devote a disproportionate share of their total expenditures to housing.[4] In fact, as Figure 1 shows, older unmarried adults, three-fourths of whom are women, on average spend more of their income on housing (39 percent) than they do for other basic necessities, including health care, food, and clothing combined (34 percent). Housing is also the major cost for married persons over age 65; accounting for 29 percent of expenditures.[5]

Many older adults are "house-rich" but cash-poor. They own homes with a large amount of equity, but do not have adequate cash flow even to cover housing expenses such as utilities, maintenance, property taxes, and physical modifications required to allow for aging in place[6] and independent living.

Figure 1. Average Annual Expenditures by Category of Unmarried Adults Age 65+



Source: Urban Institute. "Understanding Expenditure Patterns in Retirement." January 2005.

Unfortunately, at the same time, nearly 30 percent of older homeowners are both house-poor—their house is of low market value—and cash-poor.[7]

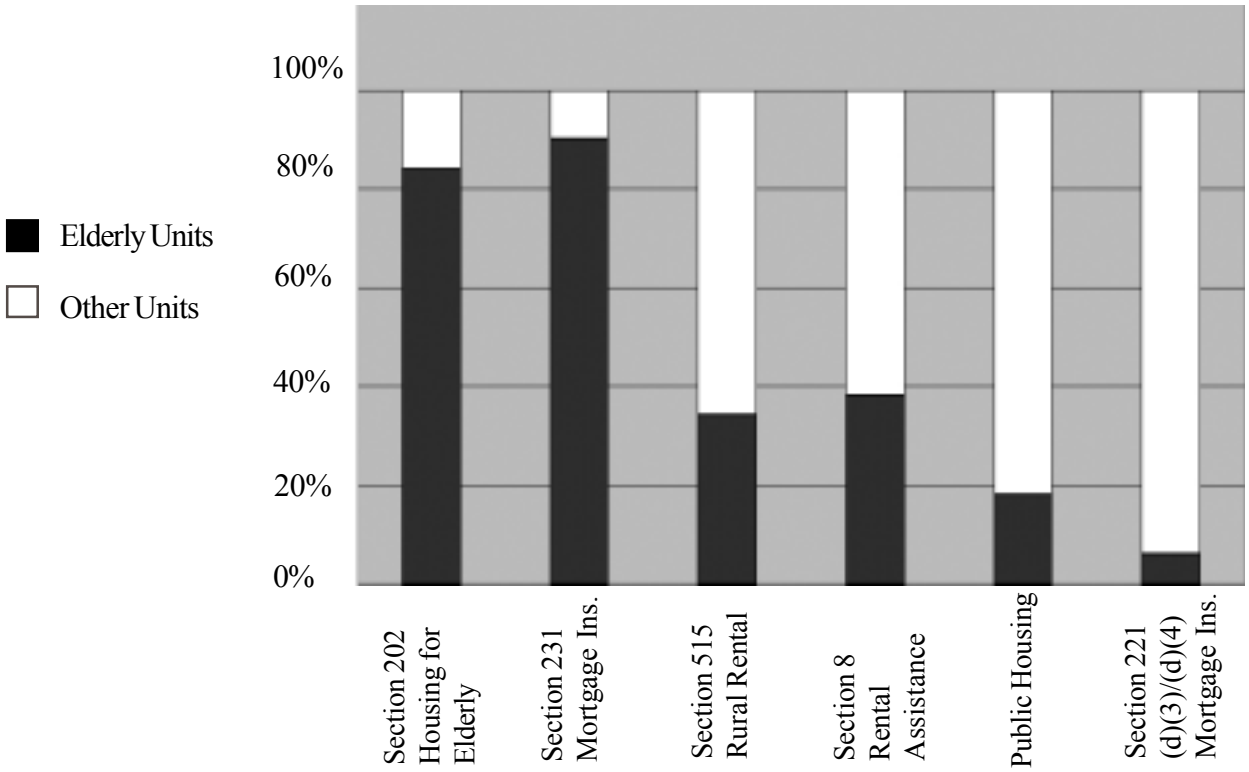
In addition, the isolation and substandard housing older Americans living in rural areas experience must be addressed. Rural areas have little to non-existent public transportation and a limited social service infrastructure. Twenty-seven percent of all older households are in non-metropolitan areas. Approximately 426,000 or 8 percent of rural older households have housing quality problems. Over 44 percent of rural elderly households consist of a person living alone; 77 percent of them are women who are vulnerable to slipping into poverty as they age.[8]

Federal Housing Programs for Seniors

Federal housing programs are critical to low and moderate-income seniors. Older persons occupy at least 1.3 million units or approximately 30 percent of the households participating in federal programs for which data is available. Figure 2 shows the percent of units designated for elderly in major federal housing programs although the actual occupancy rates are often higher.[9]

The **Section 202 Supportive Housing for the Elderly**[10] program provides funds to nonprofit organizations to develop affordable rental housing exclusively for very low-income elderly households. Approximately 25 percent must be set aside for rural areas. In 2004, there were an estimated 266,251 Section 202 units designated for the elderly.[11] However, the program reaches only an estimated 8 percent of very low-income elderly renter households and there are as many applicants waiting for admission as there are residents currently residing in available units.[12] Many communities have multi-year waiting lists.

Figure 2: Federal Housing Programs with Units Designated for Elderly, 2004



Source: General Accounting Office. "Elderly Housing: Federal Housing Programs that Offer Assistance for the Elderly." February 2005.

Federal funding for Section 202 has sharply declined from a peak of nearly 25,000 annually funded units in the 1970s, to 15,000 in the early 1980s, 11,000 in the late 1980s to just 5,200 in recent years. The fiscal year 2005 appropriations for Section 202 funds fewer than 5,000 new units. More than 1.5 million older persons are living in housing that costs too much, is in substandard condition or fails to accommodate their physical capabilities or required assistance levels. Thus, allocations for this senior housing program represent only .03 percent of the minimum units ill-housed seniors desperately need.[13]

Section 8 is a rental assistance program designed to fill the gap between fair market rents and the rents charged to low-income persons. It is a major housing support for low-income older and disabled families. Section 8 assistance may be project-based, providing subsidies to landlords who agree to rent to low-income families and individuals, and tenant-based, providing low-income persons rental assistance in the form of rental certificates and vouchers, now called Housing Choice Vouchers. Thirty-eight percent of Section 8 project-based rental assistance is designated for the elderly. Inadequate funding as well as disincentives for private owners to accept voucher-holding tenants have drastically restricted the supply of such housing and displaced many occupants from affordable housing.

Without restraints, the practice of property conversion could dramatically reduce the supply of affordable housing for older Americans.

Key to a national housing policy is recognition that suitable and affordable housing and services help not only America's seniors but also their families who care about them.

The **Section 515 Rural Rental Housing Program** has been a major funding source for rural housing for a number of years through the Rural Housing Service (RHS) of the U.S. Department of Agriculture. Thirty-four percent of Section 515 units are designated for the elderly. During its peak years in the early 1980s, the Section 515 program produced more than 20,000 units annually. Funding for the program fell sharply afterwards to an annual production of under 2,000 new units today.[14] Since its start in 1963, 523,000 rental units have been produced for low-income rural residents but more than half are at risk of loan prepayment by project owners and conversion to market rents.[15]

The **Section 231, 221 (d)(3) and (d)(4) programs** insure private mortgage loans to for-profit and non-profit owners to encourage the construction or substantial rehabilitation of multifamily rental or cooperative housing. The Section 231 program, which designates 90 percent to elderly units, has largely been replaced by the two Section 221 programs, which designate 18 percent of units as elderly.

Public housing provides affordable rental housing for low-income families, including the elderly and disabled, through 3,000 local public housing authorities. Although 6 percent are designated for the elderly, over one-third of public housing residents are seniors due partially to aging in place.

The housing shortage for older adults is exacerbated when owners of rental properties opt out of low-income, federally subsidized housing programs. The problem is particularly acute when federal contracts expire for properties located in desirable locations. Owners then have a strong incentive to remove their properties from federally subsidized housing programs and put them on the private market. Between 1996 and 2001, the conversion of government-subsidized properties to market rate rentals resulted in a decline of over 20,000 units in elderly properties.[16] Without restraints, the practice of property conversion could dramatically reduce the supply of affordable housing for older Americans.

Supportive services are essential to aging in place. Developing and maintaining affordable, comprehensive, and dependable community-based services is necessary in order to provide the range of care older persons needs as they age. Such services include personal care, transportation, assistance with daily and household tasks, and structured social activities. Approximately one-third of older tenants living in government-subsidized housing require assistance with activities of daily living. However, only 4 of 23 housing assistance programs provide grants and funding to owners of properties to ensure that supportive services are available.[17] Four other programs require that supportive services be made available to elderly residents but do

not provide funding. The **HUD Congregate Housing Services Program (CHSP)** has made modest grants to public housing agencies and Section 202 housing projects since 1978 to cover the costs of service coordinators, meals and a range of other non-medical supportive services for frail elderly and non-elderly disabled persons. No new grants have been awarded since 1995 although Congress has provided funds annually to extend expiring grants on existing projects.

Since 1990, the HUD **Service Coordinator Program** has provided federal funds to owners of federally assisted senior housing projects to hire service coordinators to assist frail residents in obtaining supportive services in the community. These services are intended to help seniors live independently and to prevent premature and inappropriate institutionalization. In 2003, service coordinators were serving more than 111,000 units in senior properties.[18] Despite the critical role that this program has demonstrated in assisting frail and at-risk seniors to maintain their independence and remain in the home, federal funding is very limited, uncertain, and in recent years primarily available only to extending current contracts.

Assisted living facilities are the fastest growing option in senior housing accounting for 75 percent of new senior housing. Assisted living facilities coordinate personal services in a congregate residential setting that accommodates changing needs and preferences as residents age. However, most are expensive—monthly fees may exceed $2,000.[19] The HUD **Assisted Living Conversion Program (ALCP)** provides grants to non-profit elderly housing properties for the conversion of some or all of their housing units into assisted living. However, no ALCP funds may be used for any of the supportive services that the owner is required to provide, including meals.

State and Local Efforts

Beyond increased federal funding for subsidized housing and a range of services for those who are aging in place, other solutions for increasing affordable housing lie with states and local communities. State and local governments have a range of funds, governances, and other resources that have been used to develop, rehabilitate, and preserve affordable housing for older persons, as well as for infrastructure and related services. Funds for housing or related services include federal HOME Investment Partnerships and Community Development Block Grants (CDBG) programs, bonds, tax incentives, general funds and state or local housing trust funds.

Numerous urban areas are undergoing substantial revitalization efforts with multi-purpose buildings accommodating businesses and apartments. The resulting rents, however, are often out of reach for moderate and low-income families. Some local governments have used "inclusionary zoning" policies that require developers of new apartments, townhouses, and multi-unit buildings to allocate a specific percentage of units to individuals at various income levels in return for concessions and profitable incentives. These requirements can include density bonuses—allowing more units per lot—that reduce construction costs and increase ultimate income. While this approach does not usually need an infusion of public money, long-term success requires that price controls remain in place for decades.

Resourceful housing options for older persons are often limited by restrictive state and local zoning policies. Zoning ordinances can set up barriers to supportive housing arrangements such as shared housing, accessory apartments, and co-housing (See Box). States can play an

important role in reducing these barriers with enabling legislation that sets the ground rules for local land use controls encouraging affordable housing development.[20] Local jurisdictions can take the lead with public education to decrease "not-in-my-backyard" resistance. States also can initiate home repair and retrofitting programs for qualified seniors and those with disabilities.

Innovative Housing Arrangements

Shared Housing. In shared housing, common living space is shared and at least two unrelated persons reside. It may be agency sponsored where people who have space in their homes are matched with individuals looking for an affordable place to live. Individuals also make their own arrangements through an agreement with friends and acquaintances to economize. A benefit in addition to saving on housing expenditures is companionship.

Accessory Apartments. Accessory apartments differ from shared housing in that occupants have their own kitchens, bath, and often own entrance. The concept originated in Australia as "granny flats." It may be a completely private living space installed in the extra space of a home or a separate structure on the same lot. They offer a way for families to provide nearby housing for parents and grandparents while they maintain their independence.

Co-Housing. This type of housing began in Denmark in the 1960s and was introduced in the United States in the late 1980s. A co-housing community combines private space and communal living. They are designed and managed by residents and usually consist of single family homes clustered on a pedestrian street or around a courtyard. The orientation of buildings encourages social interaction and a sense of community. Residents share a common building where meals are prepared and shared two or three times a week, and may include other rooms for daily use such as a laundry, workshop, library or exercise room.[21]

Recommendations

Key to a national housing policy is recognition that suitable and affordable housing and services help not only America's seniors but also their families who care about them.

The following recommendations require action on the part of Congress, the Bush administration, and state and local governments.

- **Housing Construction**. Congress should increase federal funding for HUD's Section 202 program for the construction of at least 60,000 units of new supportive housing designed for low and moderate-income seniors.

- **Coordination**. A federal Interagency Council on Meeting the Housing and Service Needs of Seniors should be established to serve as the focal point for the development, streamlining, and oversight of federal policies, programs, and resources to increase the availability and effectiveness of affordable senior housing and link supportive services and care.[22]
- **Services**. Congress should increase funding for a range of congregate and community-based supportive services and health care to meet the varied needs of older persons at different stages of their lives.
  - Congress should increase funding for the staffing of well-trained service coordinators in public and federally assisted senior housing, as well as sufficient funds for coordinators in the routine operating budget of projects.
  - Congress and the Administration need to promote, fund, and facilitate increased collaboration between housing, and social and health care services, including the development and use of technologies and exemplary models.[23]
- **Preservation**. To maintain federally assisted housing and avoid its conversion to market rate use, Congress should enact a preservation program that would provide federal funds matched by other state or local resources with flexibility to use for preserving affordable housing for low and moderate-income older persons.
- **Federal, State and Local Initiatives**. Congress and the Administration should develop additional resources to enable funding for non-profit housing and services for seniors, including a national housing trust fund, with a dedicated funding stream, that would provide much needed resources possibly supplemented by funds from state housing finance agencies.
- **State and Local Government Policies**. They should address housing, health care and other needs of older persons as part of a comprehensive community-wide, intergenerational strategy. They can change zoning laws to encourage developers to include a supply of affordable housing units within new construction. They should also allow for the establishment of alternative housing arrangements in single-family residential areas.

Conclusion

As the Seniors Commission documented, the existing and projected need for suitable and affordable housing for increasing numbers of seniors is woefully inadequate. Legislatures and government agencies on all levels of governments should develop a public housing policy and long-range strategies to ensure adequate federal, state and local resources are directed to the provision of adequate supportive services and the development, rehabilitation and preservation of suitable and affordable housing for older Americans.

Suitable and affordable housing needs to be clearly recognized as an essential part of long-term care and one of the core components of quality of life for older persons and their families. All other essential elements—economic, health and social well-being—revolve around whether one has a home that is adequate, affordable and accessible. Meeting the housing, health care and supportive service needs of increasing numbers of seniors needs to become a national priority.

Endnotes

[1] This is the title of the final report of an 18-month study mandated by Congress, the most comprehensive examination of housing needs of older Americans to date. The commission's full title is frequently shortened to the "Seniors Commission." See following end note.
[2] "A Quiet Crisis in America." A Report to Congress by the Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century. Washington, D.C. June 30, 2002.
[3] U.S. Government Accountability Office. "Elderly Housing: Federal Housing Programs that Offer Assistance for the Eldery." February 2005.
[4] Housing expenditures include mortgage payments, property taxes, insurance, rent, utilities and maintenance.
[5] Butrica, Barbara A. et. al, "Understanding Expenditure Patterns in Retirement." The Urban Institute. January 2005.
[6] Aging in place refers to growing older where one lives without having to move.
[7] "A Quiet Crisis in America."
[8] Housing Assistance Council. "Rural Seniors & Their Homes." January 2004.
[9] U.S. Government Accountability Office. February 2005.
[10] Most federal housing programs use the term "elderly," which is defined as individuals aged 62 and older. An elderly household is one in which the head or spouse is elderly. Although the Section 202 program currently targets the elderly only, not all units are so designated because the program also produced housing for the disabled until 1993.
[11] U.S. Government Accountability Office. February 2005.
[12] For example, the Elderly Housing Development and Operations Corporation (EHDOC), a non-profit corporation providing affordable housing for 4,000 low and moderate-income seniors in 42 housing facilities in 14 states, reports that it has 4,200 on a waiting list. www.ehdoc.org
[13] "A Quiet Crisis in America."
[14] U.S. Government Accountability Office. February 2005.
[15] Housing Assistance Council. January 2004.
[16] Elderly properties are those where 50 percent or more of the households are age 62 or over.
[17] U.S. Government Accountability Office. "Elderly Housing: Federal Housing Programs and Supportive Services." June 16, 2005.
[18] Ibid.
[19] Housing Alliance Council. January 2004.
[20] For example, with grants from the Coming Home Program of the Robert Wood Johnson Foundation, eight states (Alaska, Arkansas, Florida, Iowa, Maine, Vermont, Washington, and Wisconsin) have made regulatory and reimbursement changes to develop affordable assisted living for frail low-income seniors in smaller communities.
[21] www.cohousing.org.
[22] A bill (S.705) has been introduced in the Senate by Senator Paul Sarbanes (D-MD) that would establish such an interagency council to promote coordination and collaboration among the federal agencies that provide housing, health care, and other services to seniors.
[23] One such model is the Program of All-inclusive Care for the Elderly (PACE) administered by the Centers for Medicare and Medicaid Services and available in 18 states. Medical institutions provide care and social services in participants' homes or at day care centers. The program integrates Medicare and Medicaid financing. Individuals must be certified as eligible for nursing home care.

This is the sixth in a series of issue briefs from the Alliance for Retired Americans Educational Fund on issues and programs that should be considered at the White House Conference on Aging scheduled for December 11-14, 2005 in Washington, D.C.

This report was researched and written by Dianna M. Porter, director for policy. ARAEF gratefully acknowledges Steve Protulis and Larry McNickle, executive director and consultant, respectively, at the Elderly Housing Development and Operations Corporation, for their reviews and comments.

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Issue Brief

Alliance for Retired Americans EDUCATIONAL FUND

Vanishing: Pensions and Savings

No.7 | September 2005

Introduction

Since the creation of the first pension plan in the late 1880s traditional defined benefit pensions have played a significant role in retirement security for older Americans. Recently, however, defined contribution savings plans have been replacing defined benefit plans, which offer greater protection. The movement away from guaranteed benefits creates the potential for economic hardship for millions of Americans during their retirement years.

This report examines the shifting trends in employer-sponsored pension and retirement savings plans in the private sector[1]; and makes recommendations for protecting existing benefits and expanding coverage for those workers who are not participating in any plan.

Threats to Traditional Pensions and Retirement Security

The typical distinctions between traditional defined benefit, defined contribution and cash balance plans in the private sector can be seen at a glance in Table 1 and in more detail on page 4. Briefly, defined benefit (DB) is a pension plan, defined contribution (DC) is a savings plan, and cash balance (CB) is a hybrid between the two-a defined benefit with defined contribution characteristics. Collectively, they are referred to as employer-sponsored retirement plans.

Ascendancy of Defined Contribution (DC) Plans. The growth in retirement savings plans at the expense of defined benefit pension plans has led retirees and workers to take on more risk in their retirement incomes. Defined contribution plans were initially intended as added savings vehicles to supplement traditional pension plans but over the last 30 years they have been replacing rather than supplementing defined benefit pension plans as employers are encouraging workers to build up their own savings and bear the risk in DC plans such as 401(k)s.

The percent of workers in DB plans has declined by over one-third during the 1990s although maintaining a steady level around 20 percent since 1999 (see Figure 1). DC plans have grown steadily during the same time period with 35 percent of workers participating in a DC plan in 1990-91 rising to 42 percent in 2005, double the percentage of workers in DB plans. Some workers participate in both types of plans, though the decline in DB plans is slowly eroding dual coverage.[3]

Table 1. Characteristics of Retirement Plans[2]			
	Defined Benefit	**Defined Contribution/401(k)**	**Cash Balance**
Participation	Automatic	Voluntary	Automatic
Contributions	Employer	Employee and employer	Employer
Investment risk rests with	Employer	Employee	Employer
Benefits determined by	Years of service and career avg. pay*	Contributions and investment returns	Pay credits and interest credits
How benefits are typically paid	Annuity or lump sum	Lump sum	Lump sum**
Access to funds before retirement/termination of employment	No	Yes***	No
Guarantee by PBGC	Yes	No	Yes
Access to benefits after termination of employment/ before retirement	No	Yes	Yes

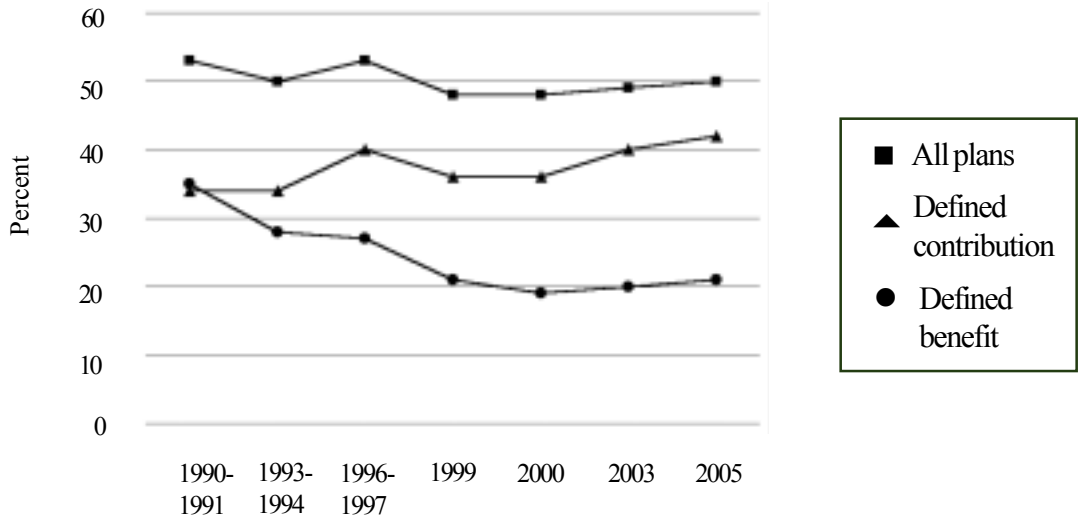
* In most collectively bargained plans, monthly benefits are a flat dollar amount (e.g., $30) multiplied by years of service.
**With the option to take an annuity
*** Loans and hardship withdrawals

As pensions are often a collective bargaining benefit, union workers are nearly five times more likely to be participating in a DB plan than nonunion workers (72 percent vs. 15 percent) and slightly more so in DC plans (43 percent vs. 41 percent).[4]

Within limits, workers with DC plans decide how to invest the assets and bear the risk of returns. Many workers, however, lack financial acumen for making investment decisions. Workers in DC plans do not have the insured protection of the Pension Benefit Guaranty Corp. (PBGC) and are particularly vulnerable to poor market returns. Because DC plans pay benefits out as lump sums and very few workers use their DC benefits to purchase annuities, workers also bear longevity risk—the risk that they will outlive their savings.

Underfunding of DB plans. DB plans are insured by the PBGC with limits on benefits, adjusted each year. The 2005 maximum PBGC insured benefit for a 65-year-old individual is $45,614.[5] Sponsors of DB plans pay annual flat and variable rate premiums to the PBGC for its coverage.[6] A number of events and practices, however, have led to the PBGC running a deficit.[7] Many pension plans are underfunded as a result of large stock market declines since 2000 and the concurrent drop in interest rates to historically low levels. Widespread bankruptcies in the steel and airline industries led to the termination of many pension plans in those industries with significant unfunded liabilities. Some employers began to look for ways to avoid their obligations or shift some of the risks to workers by terminating their DB plans.

Figure 1. Percent of Private-Sector Workers Participating in Employer Retirement Plans, Select Years



Sources: U.S. Department of Labor. Bureau of Labor Statistics. "Documenting Benefits Coverage for All Workers." May 26, 2004; and "National Compensation Survey, March 2005," August 2005.

This has put a tremendous financial strain on the PBGC. While the PBGC had $9.7 billion more than needed to pay benefits in all plans in its single employer program at the end of fiscal year 2000, the federal agency reported a record actuarial deficit of $23.3 billion at the end of fiscal year 2004.[8]

There are proposals under consideration in Congress that would require employers to fully fund their plans as well as pay higher premiums to the PBGC.

Lump Sum Distributions. Both DC and CB plans, and increasingly DB plans, allow for lump sum disbursements at retirement or when a worker changes jobs, instead of the standard monthly annuity. In DC plans, workers may borrow against their accounts or withdraw assets while they are still working under certain circumstances. When changing jobs, most workers take a lump sum payment if available even with tax penalties rather than transferring to an individual retirement account (IRA) or other tax-advantaged retirement account. Workers at retirement typically take the account as a lump sum. To convert an account to an annuity, a periodic payment that typically lasts as long as the annuitant lives, a worker has to purchase it separately from an insurance company. Those who do not convert to an annuity take a chance they will outlive their retirement assets. With DC plans, few workers transfer their accounts when changing jobs and few retirees buy annuities.[9] DB and CB plans must, by law, provide annuities as the default form of benefit, but they can offer lump sums as an alternative benefit form.

Conversion to Cash Balance Plans. In addition to a shift from DB to DC plans, there has also been a shift from traditional DB to cash balance plans.[10] The proportion of DB plans that are cash balance has risen from 4 percent in 1996-7 to approximately 20 percent today.[11]

Retirement Plan Basics

Defined Benefit. A traditional pension plan that uses a specific predetermined formula to calculate the amount of an employee's future benefit, usually a calculation of the number of years of service and a measure of the worker's average salary over a career or the number of years service and a fixed dollar amount. Employers make the contributions, make the investment choices and bear the direct financial risks. Taxes are deferred until benefits are paid. Benefits are insured by the Pension Benefit Guaranty Corporation (PBGC) and usually paid as an annuity. A 2004 law, however, requires automatic rollover to an IRA for small distributions under $5,000.

Defined Contribution. Under the most common type of DC plan, known as a 401(k), employees contribute a predetermined portion of their earnings (on a tax-deferred basis) to an individual account, all or part of which may be matched by the employer. These plans do not have the insured guarantee of the PBGC. At retirement, the worker receives the account balance-the total of deposits and investment income-usually in a lump sum, which is subject to taxation unless the money is transferred to an IRA or another job-based retirement plan.

Cash Balance. A cash balance plan is a hybrid pension plan-a defined benefit plan that has some characteristics of a defined contribution plan. The employer makes the contributions and investment choices and bears the investment risk. The employee's promised future benefits are stated as a hypothetical account balance, which grow with annual pay and interest credits. Unlike in a DC plan, benefit levels are unrelated to the actual investment performance of the plan's underlying assets. In almost all CB plans, workers may take a lump sum distribution of their account or transfer it to an IRA or another job-based retirement plan at termination of employment or retirement. Income tax must be paid when benefits are withdrawn. Benefits are insured by PBGC.

Cash balance plans have been controversial because of their impact on older workers, although other court decisions upheld conversions. In 2003, a federal district court ruled that the basic design of a cash balance plan at IBM violated the age discrimination rules.[12] Furthermore, conversions from traditional DB plans to CB plans frequently have resulted in reduced future benefits for older workers, depriving them of a large part of the benefits they expected to earn, as well as resulted in periods of years in which some older workers earn no new benefits under the plan.

Inequalities in coverage.[13] Those who lack retirement plan coverage generally are workers in part-time or low-wage jobs or who work for smaller companies. Among service workers, only 7 percent participate in a DB plan and 18 percent participate in a DC plan. Similarly, only 9 percent of part-time workers participate in a DB plan; 14 percent in a DC plan.[14]

Even when an employer has a retirement savings plan that covers all employees not all may participate. Low-wage workers in particular have a lower participation rate than high-wage workers. While participation is automatic for workers covered by DB plans, it is usually optional under DC plans. Many workers do not participate because of age, service and number of hours requirements that hinder participation.[15] However, one-quarter of workers with an available plan say that they choose not to participate.[16] And if they do participate, they typically contribute a smaller percentage of their pay than higher wage earners.

Automatic enrollment in a retirement plan is one means of encouraging participation by moderate and low-income workers. A recent analysis showed that, before the adoption of automatic enrollment, only 12.5 percent of workers with annual earnings under $20,000 participated in a 401 (k) plan but after adoption of automatic enrollment, 70.5 percent participated.[17]

Three-fourths of uncovered workers are employed in small companies without a pension plan. Only 10 percent of employers with fewer than 100 employees offer a DB plan and 47 percent offer a DC plan whereas 32 percent of large employers (over 100 employees) offer a DB plan and 87 percent offer a DC plan.[18] In response to reports that small employers do not offer a retirement plan because of cost and administration related reasons, Congress enacted legislation in 1978 to encourage small employers to establish Simplified Employee Pensions (SEP). In 1996, Congress authorized the Savings Incentive Match Plans for Employees of Small Employers (SIMPLE). Both require little paperwork and no government reporting if certain rules are followed. While this has increased coverage by small employers somewhat, additional incentives may be needed.

Pension integration. One of the most unfair provisions in retirement plans, pension integration allows an employer to deduct part of a beneficiary's Social Security payments—up to 50 percent from promised pension benefits in order to reduce plan payouts.[19] Integration particularly adversely affects women who are the majority of low-wage workers.[20]

Corporate Fraud. Tens of millions of retirees and workers have lost or had 401 (k) benefits severely reduced because of corporate fraud and abuse such as the Enron and WorldCom scandals of 2001-02. Despite these events, workers still are heavily invested in company stock and susceptible to corporate exploitation. One study by Hewitt Associates found that more than one in four workers in large companies held half or more of their 401(k) balances in employer stock; many are not diversifying by selling company stock and one in five are not contributing enough to qualify for the employer match.[21]

Pension assets should be considered the property of the employees. ERISA legislation states that pension plan money must be used exclusively for the benefit of workers and retirees. All assets of a pension plan, including employer contributions, are deferred wages. Deferred wages are trade-offs for a promise of a pension that is expected to continue and grow in value and provide adequate retirement income for long-service employees. Workers need representation on the boards of trustees to ensure protection.

Termination and Freezing of Plans. Plan termination can occur not only in bankruptcy situations but also in cases where an employer simply wants to limits its financial outlays. A growing number of employers are cutting off traditional pension plans by freezing benefits particularly for young employees and not offering its pension plan to new hires.[22] By freezing pensions, workers retain the benefits they have already accumulated but lose the potential for further accruals. In a termination, an employer closes down a plan, and defaults to the federal government or moves the pension funds into an insurance policy that will eventually pay out to workers. According to the consulting firm, Watson Wyatt Worldwide, this is a growing phenomenon—the percentage of companies with a frozen or terminated plan rose to 11 percent in 2004, up from 7 percent in 2003, 6 percent in 2002, and 5 percent in 2001.[23]

Low Personal Savings. Personal savings in the United States cannot be much lower. Savings by individuals has declined from 7.2 percent in 1980 to 0.9 percent in 2004.[24]

Employers can encourage more savings by making a substantial match to 401(k)s and other savings accounts. One study found that workers increase their contributions to Individual Retirement Accounts (IRAs) by four times when they receive a 20 percent match to their contribution and they boost their contributions by eight times when they receive a 50 percent match.[25]

A "Saver's Credit" provision was included in the Economic Growth and Tax Relief Reconciliation Act (EGTRRA) of 2001 to encourage low and moderate-income workers to save for retirement.[26] However, since the credit is nonrefundable, it does not provide incentives to save for those whose income is so low they do not file income tax returns. The credit phases out at modest incomes and it is scheduled to expire at the end of 2006.

Recommendations

The primary goal of any pension reform should be to expand coverage and participation while protecting existing rights of current and future retirees. The following recommendations address that goal.

Expand Coverage and Participation. The lack of pension coverage for a significant segment of the workforce is a serious matter. Low and moderate-wage earners in particular end up without any significant source of retirement income other than Social Security. If adopted, whether by Congress, regulators or employers, the following measures would advance coverage and participation significantly.

- Advance the earliest possible vesting of employer contributions.
- In workplaces with no retirement plan, encourage the creation of hybrids such as cash balance plans that combine the best features of DB and DC plans.
- Institute automatic enrollment in workplace retirement plans, whether DB, DC, or hybrid. Workers could still opt out but would need to take specific action to do so.
- Encourage workers to commit a portion of future pay raises to retirement plan.
- Establish greater tax incentives for employers who start plans or agree to cover all their workers.
- Establish a national educational campaign for employers that explains the importance of starting pensions and retirement savings plans for workers.
- Create more incentives for employers to adopted Simplified Employee Pensions (SEPs).
- Increased employer to employee education about a plan's benefits.

Preserve Current Coverage and Increase Savings.

- In conversions from DB plans to cash balance plans or similar hybrids, older workers must have protections to avoid loss of valuable benefits.
- Expand the Savers Credit limit and make it refundable, permanent and available to those with somewhat higher incomes than currently allowed.

Protect Workers' Interests

Although Congress enacted legislation in 2004 (P. L. 108-218) that addressed some pension issues it did not go far enough. Stricter governance and oversight of retirement plans and those who administer them are still necessary.

- Workers should be encouraged to not cash out or borrow against their DC plans.
- There should be representation of workers and retirees on the boards of trustees of defined benefit pension plans, 401(k) and similar retirement savings plans. The trustees should be insured in the event they are found to have acted unlawfully and plan participants need to be made whole.
- Loopholes that allow companies to underfund pensions should be closed. Plan sponsors should be held accountable for adequately funding their plans.
- Full disclosure of the financial status of the fund and explanation of participants' rights should be provided by the plan sponsor.
- Those who provide financial education and investment advice to plan participants should be free of conflicts of interest.
- There must be special protections for workers when employers make retirement plan contributions in the form of their corporate stock and ample notice before employers institute lockdowns.[27]
- A national ombudsman to protect the rights of plan participants should be established within the Department of Labor.
- Workers should have a voice in the use of terminated pension assets.
- Require workplace education program conducted by impartial third parties.
- Eliminate pension integration.

Conclusion

Social Security, pensions, and personal savings and assets have long been recognized as the three legs or sources of retirement security. Recent developments in the pension and savings arenas—underfunding, stock market volatility, poor investment decisions, corporate fraud and abuse-underscore the importance of maintaining Social Security's guarantee of risk-free, inflation-adjusted lifetime protection. Nevertheless, Social Security was never meant to be the sole source of retirement income. It works best when complemented by an employer-sponsored pension and personal retirement savings. Any reforms in the retirement system must first and foremost expand coverage and participation and protect the interests of workers and retirees.

Endnotes

[1] There are thousands of public pension plans for state, county and municipal employees and several federal plans for federal workers. There are no uniform standards for public pension plans; rules determining the rights of beneficiaries are left to the discretion of each sponsoring jurisdiction. Thus, public pensions are beyond the scope of this brief.

[2] Table is adapted from similar tables in Gale, William G. and Peter R. Orszag. "Private Pensions: Issues and Options." Discussion Paper No. 9. Urban-Brookings Tax Policy Center. April 2003; and Cahill, Kevin and Mauricio Soto, "How Do Cash Balance Plans Affect the Pension Landscape?" Center for Retirement Research at Boston College, December 2003.

[3] U.S. Department of Labor. Bureau of Labor Statistics. "Documenting Benefits Coverage for all Workers." May 26, 2004; and "National Compensation Survey, March 2005," August 2005.

[4] U.S. Department of Labor. Bureau of Labor Statistics. August 2005. There are two types of DB plans insured by the PBGC: single and multi-employer. Multi-employer pension plans are created by collective bargaining agreements covering two or more employers in an industry and represent about 22 percent of workers in DB plans.

[5] The PBGC provides insurance protection for both single-employer and multi-employer defined benefit plans. According to the Government Accountability Office (GAO), this includes over 29,900 single-employer pension plans, covering 34.6 million people. Multi-employer plans cover approximately 10 million participants.

[6] The flat rate premium has been set at $19 per participant since 1991. The variable rate premium was added in 1987 to provide an incentive for sponsors to better fund their plans—for each $1,000 of unfunded vested benefits, plan sponsors pay a premium of $9.

[7] In 2003, GAO placed the PBGC single-employer insurance program on a high-risk list of government operations facing significant vulnerabilities.

[8] U.S. Government Accountability Office. "Private Pensions: Recent Experiences of Large Defined Benefit Plans Illustrate Weaknesses in Funding Rules." May 2005.

[9] Gale, William G. and Peter R. Orszag. op.cit.
[10] In addition to attractive design features of cash balance plans, many employers wishing to terminate their traditional DB plan, have found that converting to a cash balance plan has greater tax advantages than converting to a DC plan.
[11]U.S. Government Accountability Office. "Comptroller General's Forum: The Future of the Defined Benefit System and the Pension Benefit Guaranty Corporation." June 2005.
[12] Cooper v. IBM. So.District of Ill. IBM is appealing the decision.
[13] Coverage and participation have different meanings—coverage means an employer has a plan but the employee may not be in the plan; participation means the employee is enrolled in the plan. In DB plans, enrollment is automatic so it is often used synonymously with coverage. In DC plans, there is a distinction.
[14] U.S. Department of Labor. Bureau of Labor Statistics. August 2005.
[15] The minimum participation provisions of the Internal Revenue Code allow employers to exclude employees under age 21 or with less than one year of employment with the employer.
[16] Munnell, Alicia H., et. al. "How Important Are Private Pensions?" Center for Retirement Research at Boston College. February 2002.
[17] Gale, William G. et al. "Improving Tax Incentives for Low-Income Savers: The Saver's Credit." Tax Policy Center. June 2005.
[18] U.S. Department of Labor. Bureau of Labor Statistics. August 2005.
[19] Through integration, employers are able to take credit for the fact that their Social Security contributions for lower-income workers "buy" proportionately more generous benefits than their contributions for higher earners.
[20] OWL, the voice of midlife and older women. "The State of Older Women in America."
[21] Associated Presss. "Participation Climbs in 401(k) Accounts." May 10, 2005.
[22] Companies that have frozen or terminated their pensions include Hewlett-Packard Co, IMB Corp., and Sears.
[23] Associated Press. "Pensions Freezing Out Younger Workers." July 24, 2005.
[24] Eschtruth, Andrew and Robert Triest. "National Saving and Social Security Reform." Center for Retirement Research at Boston College. April 2005.
[25] Retirement Security Project. May 9, 2005.
[26] The Saver's Credit provides a government matching contribution in the form of a nonrefundable tax credit for voluntary contributions to 401(k) plans, IRAs, and similar retirement savings arrangements up to 50 percent for as much as $2,000 in contributions for married couples earning less than $30,000 and single filers earning less than $15,000.
[27] Lockdowns are periods when workers are prohibited from selling the employer's stock.

This is the seventh in a series of issue briefs from the Alliance for Retired Americans Educational Fund on issues and programs that should be considered at the White House Conference on Aging scheduled for December 11-14, 2005 in Washington, D.C.

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